WESTERN DUPAGE OBSTETRICS & GYNECOLOGY

Confidentiality Authorization Form

I _____, authorize the following persons to discuss/receive medical results on my behalf:

_____

_____

_____

Results may be disclosed by:

__ Telephone __ Voicemail __ Email __ Fax

__ All of the above

Date: ___/___/___

Signature: _____

Please fax/email form back to:
Western DuPage Obstetrics & Gynecology: Attn: Reception
F 630.810.0395
westerndupageobgyn@gmail.com