Patient Name________________________________
Address______________________________________
____
Phone #____________________
Date of Birth____/____/____

WESTERN DUPAGE OBSTETRICS & GYNECOLOGY S.C.
3800 HIGHLAND AVE. SUITE 105
DOWNERS GROVE, IL 60515
P 630.810.0777 F 630.810.0395
westerndupageobgyn@gmail.com
www.westerndupageobgyn.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person / Institution ____
Address : ____
City: ____ State: ______ Zip: _________

TO: Person / Instiution ____
Address : ____
City: ____ State: ______ Zip: _________

Purpose or need for information: ____

Disclosure will include: (check all that apply)

□ Complete Medical Record □ Face Sheet □ History & Physical □ Laboratory Report

□ Discharge Summary □ Progress/Physician Notes □ X-Ray / Radiology □ Pathology Report

□ Emergency Report □ EKG/EMG/EEG Report □ Consultation Report

□ Other ____

Records for the period dates from _______________ to ________________

I also understand that the information to be released may include:

□ Diagnosis, Evaluation, and/or treatment for alcohol and/or drug abuse
□ Records of HTLV-III or HIV testing results, diagnosis and/or treatment
□ Psychiatric/Psychological evaluations, records, diagnosis, and treatments

I understand that this Authorization is subject to revocation/withdrawal by myself at anytimein writing to the medical record contact person at this site of care except to the extent that information has already been released. This authorization shall remain in effect unless revoked. I have the right to verify the health information to be released. If I do not sign this authorization, my records will not be released. The above named medical practice will not refuse to treat me based on my decision regarding this authorization.

___________________________________ Date _____/_____/_____
Patient Signature

___________________________________ Date _____/_____/_____ ___________________________________
Parent/Legal Guardian Signature Relationship to Patient