



OB / G Y N E

Associates of Lake Forest, Ltd.

Authorization For Release of Information

I, _____ or _____
Patient Name (Please print) Authorized Person (Please print)

Hereby authorize: Name _____
Address _____
Phone _____
Fax _____

To release to: Name _____
Address _____
Phone _____
Fax _____

Please circle your doctor:

Michael Hubbell, MD Jill Holden, MD Tanya Huang, MD
Heather Heiberger, MD Elizabeth Oh, MD Maureen Tart, MD

The following medical records relating to (check all that apply):

____ Office visits ____ Pathology Results
____ Lab Results ____ Information regarding HIV/AIDS
____ Radiology Results diagnosis or treatment
____ Other _____
(Please specify)

For the medical record of _____
Patient Name Date of birth

_____ Check here if you would like to receive your records via our Patient Portal.

The above information is being released for the purposes of: (please specify- continuing medical treatment, reimbursement, worker's compensation claims, etc.)

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

If not revoked, this authorization will expire on _____ (specify date) or 60 days after the date below, or sooner at my election.

I hereby release _____ from any and all legal responsibility
Physician Name
or liability that may arise from the disclosure or release of the information described above. This includes all liability for an alleged violation of having this information maintained in confidence and privacy. I also understand there is a _____ processing fee to be collected at the time of my request.

Please allow 30 days for processing of records.

If you are requesting your records via fax, please send us your request to the Ob-Gyne Associates Records Fax Line at (847) 234-7765.

Date

Signature

Witness

Relationship to Patient