Westmoreland Obstetric and Gynecologic Associates, S.C.

Scott Logan, MD Kelley London, MD Adam Cohan, MD

917 Sherwood Drive, Suite 200
Lake Bluff, IL 60044

1475 E. Belvidere Road, Suite 316
Grayslake, IL 60030

Phone: 847-234-9110
Fax: 847-234-0900

Permission to Release Medical Records

Patient Name: ______________________________________ Date of Birth: __________________

From: Westmoreland OB/Gyn Assoc.
917 Sherwood Drive, Suite 200
Lake Bluff, IL 60044

Send to: ____

____

____

Phone #: ___________________ Fax #: ___________________

Required Consent Below:

I do _____ / do not _____ specifically Consent to transmission of my medical via fax machine.

____

Signature Date

I hereby authorize the release of the following information contained in the medical record for the above individual.

___ Physician/Nurse's Notes ___ History & Physical Exam ___ Consultation
___ Laboratory & Pathology Reports ___ Medication List ___ X-Ray Report
___ Discharge Summary ___ Operative Report ___ ER Records
___ Other: ____

NO LIMITATION is placed on the release of information related to the testing, diagnosis and/or treatment of mental health, alcohol and/or substance use/abuse, HIV/AIDS, sexually transmitted disease of related conditions.

If desired, state LIMITATIONS to release: ____

This authorization will expire in ninety days from the date of signature, unless revoked earlier in writing.

SIGNATURE: ____ DATE: __________________________

ADDRESS: ____

CITY: ______________________________ STATE: _________ RELATIONSHIP TO PATIENT:

ZIP CODE: _________________________ SELF PARENT GUARDIAN

4/18