Westmoreland Obstetric and Gynecologic Associates, S.C.

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Permission to Release Medical Records

Patient Name: _____ Date of Birth: _____

From: _____

_____

_____

Phone #: _____ Fax #: _____

Required Consent Below:

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

_____

Signature Date

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

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