

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PLEASE PRINT CLEARLY

PATIENT'S NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

I AUTHORIZE (NAME OF DOCTOR): _____

Address

City State Zip
Telephone : _____

TO RELEASE INFORMATION FROM MY MEDICAL RECORDS AND SEND TO THE FOLLOWING:

Novas, Dohr & Coll OB/GYN Associates, S.C.
111 N. Lions Drive Suite 210
Barrington, Illinois 60010
TELEPHONE: 847-304-0044 FAX: 847-304-5885

I authorize you to release my medical record to the Physicians named above subject to the following restrictions, if any:

_____ NO LIMITATIONS-Including Mental Health Notes/HIV/Substance

_____ LIMITATIONS: check all related information that you DON'T want released:

_____ HIV/AIDS _____ MENTAL HEALTH _____ SUBSTANCE ABUSE _____
SPECIFIC RECORDS: _____ LABS _____ OPERATIVE REPORT _____ OTHER

Purpose or need for information: _____

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this authorization, the office named above will not release my health information. The above named person will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____ RELATIONSHIP: _____

WITNESS: _____ DATE: _____