OB/GYNE
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 _____

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

_____Office visits
_____Lab Results
_____Radiology Results
_____Other_____
(Please specify)

_____ Pathology Results
_____ Information regarding HIV/AIDS diagnosis or treatment

For the medical record of _____ _____
Patient Name Date of birth

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 submitting 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