

WESTWOOD OB-GYN, LTD.
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HEALTH RECORDS RELEASE FORM
CHART # _____

INSTRUCTIONS: 1. Make sure all blanks are filled in. Failure to do so may prevent or
Delay release of information.
2. Only Westwood OB-GYN, Ltd. Records will be copied.

PATIENT IDENTIFICATION: NAME _____ D.O.B. _____
S.S.N. _____
Maiden/previous names/nickname _____

PROVIDER: NAME _____
Where do you
want the information ADDRESS _____
sent?

From whom are NAME _____
We obtaining ADDRESS _____
Records?

**BE ADVISED THAT FAILURE TO AUTHORIZE THIS CONSENT MAY HAVE
MANY CONSEQUENCES SUCH AS, BUT NOT LIMITED TO DENIAL OF
INSURANCE PAYMENT.**

INFORMATION REQUESTED: _____ Clinic Visit Progress Notes (date _____)
_____ Lab Data
_____ Prenatal Visits
_____ Operative Report
_____ Pathology (date _____)
_____ Other (explain _____)

PURPOSE OF RELEASE: _____ Insurance _____ Continued Medical Care
_____ Legal _____ Other-specify below*
_____ Dissatisfaction _____ Moving
_____ Convenience of hours
_____ Convenience of location

TIME LIMIT: I understand that this consent is valid for 3 months or can be revoked at any time
prior to this time period in writing.

CHARGES: **THERE IS A CHARGE FOR TRANSFERRING RECORDS
ACCORDING TO THE NUMBER OF PAGES.**

SIGNATURE OF PATIENT _____ DATE _____
OR LEGAL REPRESENTATIVE