WESTWOOD OB-GYN, LTD.
375 N. WALL STREET, SUITE P410
KANKAKEE, ILLINOIS 60901
TELEPHONE (815) 932-7233

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Patient Name	Date of Birth	Social Security Number

Address	City	Zip	Phone

RELEASE FROM: (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/Facility			
Address	**City**	**Zip**	**Phone**

RELEASE TO: (Name of physician or facility receiving information)

Please send my medical record to:

Physician/Facility			
Address	**City**	**Zip**	**Phone**

RELEASE INFORMATION

Reason: □ Change of insurance □ Transfer of care □ Personal file
□ Moving out of area □ Specialist consultation □ Legal

Please release the following (check all that apply)

PAP REPORTS		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS (U/S)	
HOSPITAL REPORTS		OTHER:	

- Please allow 10 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

	YES	NO	Initials
I authorize the release of HIV/AIDS test results.			
I understand that I may be charged for copies provided. (See reverse side.)			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date

Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.

_____ _____ $ _____

RECORDS SENT STAFF INITIAL FEE