Westmoreland Obstetric and Gynecologic Associates, S.C.

Hugh Falls, MD Scott Logan, MD Kelley London, MD Adam Cohan, MD

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Permission to Release Medical Records

Patient Name: ______________________________________ Date of Birth: __________________

From: Westmoreland OB/Gyn Assoc.
900 N. Westmoreland Road, Ste 207
Lake Forest, IL 60045

Send to: ____
____
____

Required

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

____
Signature Date

Fax #: _________________________

I hereby authorize the release of the following information contained in the medical record for the above individual.

___ Physician/Nurse's Notes
___ Laboratory & Pathology Reports
___ Discharge Summary
___ History & Physical Exam
___ Medication List
___ Operative Report
___ Consultation
___ X-Ray 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: _________

ZIP CODE: _________________________

RELATIONSHIP TO PATIENT:

SELF PARENT GUARDIAN