DOHR, COLL & GADSON OB/GYN ASSOCIATES, S.C.

600 Hart Road, Suite 310
Barrington, IL 60010
Phone: 847-304-0044 / Fax: 888-905-2704

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE PRINT CLEARLY

Patient's Name: _____

Address: _____

City, State, Zip:_____

Date of Birth: _____ Telephone#: _____

I authorize (Name of doctor):_____

_____
Address

_____
City State Zip

Telephone#: _____ Fax#: _____

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

Dohr, Coll & Gadson OB/GYN Associates, S.C.
600 Hart Road, Suite 310
Barrington, Illinois 60010
TELEPHONE: 847-304-0044 FAX: 888-905-2704

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:_____