Gynecological & Obstetric Associates, S.C.
1614 West Central Road 205
Arlington Heights, Illinois 60005

Phone 847-392-9191 Fax 847-392-9811

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name_____
Please print (last) (first) (middle)

Address _____
(street) (city) (state) (zip)

Phone (____)_____ Date of Birth _____ Social Security #_____

I authorize (name of previous doctor) _____ to release medical information from my medical record and send it to:

Name of New Physician _____

Address _____

City/State/Zip Code _____

I authorize you to release my entire record to the physician named above subject to the following limitations if any

___ No limitations
Or (check any of the following)
___Only information related to the following:
___HIV/AIDS
___Mental Health
___Substance Abuse
___Other (Please specify and print clearly) _____
___Any medical record from another physician

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
Patient signature

Please include E Mail Address

Fee for records is based on amount of pages printed and postage if applicable

FOR OFFICE USE ONLY

Received date _____ completed by _____ completed date_____

Reason for transferring_____ fee paid _____