NOVAS, DOHR, COLL & GADSON OB/GYN ASSOCIATES, S.C.
600 Hart Road, Suite 310
Barrington, IL 60010
Phone: 847-304-0044 / Fax: 888-905-2704
www.novasassociates.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please Print Clearly

Patient's Name:_____

Address:_____

City, State, Zip_____

Date of Birth:_____Telephone #;_____

I authorize: **Novas, Dohr, Coll & Gadson Ob/Gyn Associates, S.C.**

To release information from my medical records and send to the following:

Name of Physician:_____

Address:_____

City, State, Zip_____

Telephone #:_____Fax #:_____

I authorize you to release my medical record to the Physician named above subject to the following restrictions, if any:

_____NO LIMITATIONS-Including Mental Health Notes/HIV/Substance Abuse

_____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 there is a fee for medical record release. This is due at the time of request.

WE DO NOT RELEASE COPIES OF RECORDS IN OUR POSSESSION THAT ARE RECEIVED FROM ANOTHER PHYSICIAN.

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/institution 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_____

Witness:_____Fee Paid:_____MD Review:_____