MEDICAL RECORD RELEASE FORM

Patient Name:_____ **Date of Birth:**_____/_____/_____

I hereby authorize and request: to disclose the following information to:

Name of Physician/Institution:_____

Address:_____

_____

Phone:_____

Aishling Obstetrics and Gynecology

831 E. Sandhurst	654 W. Veteran's Pkwy	15905 S. Frederick St
Sandwich, IL 60548	Suite A	Suite 109
(815) 786-1088	Yorkville, IL 60560	Plainfield, IL 60586
(877) 262-BABY	(630) 553-3588	(815) 577-2840
Fax (815) 786-1314	(630) 553-3525	Fax (815) 577-2845

Covering the periods of healthcare from (date) _____/_____/_____ to (date) _____/_____/_____

Information to be disclosed:

___ complete health record ___ discharge summary ___ history and physical

___ progress notes ___ consultation reports ___ laboratory tests

___ xray reports ___ ED record ___ rehab notes

___ Other (please specify)

_____

I understand that this will include information relating to (check if applicable):

___ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection

___ Behavioral health services/psychiatric care

___ Treatment for alcohol and or drug abuse

Purpose for disclosure: (circle one) continued treatment reimbursement evidence of care legal counsel

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 days from the date signed.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ Date:_____/_____/_____
(Patient or patient representative) (Relationship to patient)

Witness: _____ Date:_____/_____/_____

Thank you for your assistance in this matter,

James Hawkins, D.O., F.A.C.O.G.
Brett J. Cassidy, M.D., F.A.C.O.G.
Deann Ryan, C.N.M., W.H.N.P.