Lake Shore Obstetrics & Gynecology Medical Records Release Form

680 N. Lakeshore Drive Suite 824 Chicago, IL
Phone: (312) 943 3300 ● Fax: (312) 943 4069

Patient Information

Patient Full Name **Print** — Date of Birth (Month/Day/Year)

Street Address — City — State, Zip

Social Security Number (Last 4) — Daytime Phone Number ◯ Cell ◯ Home ◯ Work

Release Medical Records From:	**Send Medical Records To:**
Doctor/Hospital	Doctor/Hospital
Street Address	Street Address
City State/Zip	City State/Zip
Phone Number Fax	Phone Number Fax

Information to be Released:

*The following information will be sent unless you indicate otherwise: (Progress notes, Labs, Radiology, Operative/Pathology Report, other diagnostic tests and consultation reports).

*This abstract will include sensitive information such as mental health, substance abuse and/or HIV/AIDs unless circled below:

Mental Health Substance Abuse HIV/AIDs

Release the following records

_______ 5 years medical records including progress notes and diagnostic results

______ Current Prenatal Records – Transfer of Care

_______Only some portion of records/ Please indicate specific description of information to be released (including date(s) as applies)

What is the purpose of the use or disclosure? If you do not wish state the purpose, indicate "at patient's request".

The practice will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

Please Read and Initial the Following Statements:

1. I understand that my healthcare and payment for my health care will not be affected if I do not sign this form. **Initials______.**
2. I understand that I may see and copy the information described on this form if I ask for it, and LSOBGYN will give me a copy of this form after I sign it. **Initials_____.**
3. I understand that this authorization will expire in six (6) months. **Initials_____.**
4. I understand that I may revoke this authorization at any time by notifying LSOBGYN in writing. The revocation will not have any effect on any actions that LSOBGYN took before it received the revocation. **Initials_____.**

Signature of patient or patient's representative — Date

Office Use Only

Physician's Signature/Initials — Scanned — Tasked — Payment Rcvd — Chart Located