

MEDICAL RECORDS RELEASE FORM

Gynecologic Specialists of Northwestern, S.C.

680 N. Lake Shore Drive Suite 117

Chicago, IL 60611

(312) 654-1166 Fax (312) 654-5288

Date: _____

I hereby authorize and request Drs. Streicher, Blumenthal and Goldman to release my medical records to:

If you are moving, please provide your new address and telephone number:

Will you be returning to our practice for further medical visits? Yes No

If yes, when? _____

Patient's Name: _____

Social Security #: _____

Date of Birth: _____

Current Address: _____

Current Phone #: _____

Patient's Signature: _____ Date: _____

I, _____, am the requesting the following (Name of Patient and/or Authorized Agent)

The entire medical record, **including** mental health, alcoholism, or drug abuse treatment, and HIV-acquired immune deficiency syndrome

From (date): _____ To (date) _____

Or please **exclude** the following:

: _____

Or, only **include** the following:

The purpose of the authorization: (check all that apply):

Moved Changing insurance Second Opinion Personal

PCP primary care physician update Changing physicians

Other:

OFFICE USE ONLY

\$ 35 Fee Collected? CASH CHECK CREDIT

Pick up/ Mail to: _____