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## Permission to Release Medical Records

Patient Name:		Date of Birth:			
From: <u>Westmoreland OB/</u>	Gyn Assoc.	Required Consent Below:			
	e, Suite 200			_	
Lake Bluff, IL 600	44	I do	/ do not	specifically	
Fax# 224-678-000 Send to:	01	Consent to transmission of my medical via fax machine.			
<del>,</del>		_ <u> </u>	e	Date	
Phone #:	Fax #:	<u></u>			
Prenatal Records Operative Report All Records Other:					
NO LIMITATION is placed of mental health, alcohol and conditions.	on the release of information rela /or substance use/abuse, HIV/A	ated to the testi IDS, sexually tro	ansmitted disea	se of related	
	ONS to release:				
	e in ninety days from the date of				
SIGNATURE:		DATE:			
ADDRESS:	. Database				
CITY: * STATE:					
ZIP CODE:		S	SELF PAREN	T GUARDIAN	