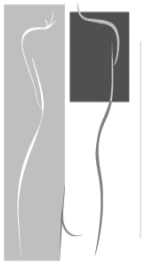

The Northwestern Specialists For Women

900 N Kingsbury Road, Ste 130N, Chicago IL, 60610.

Request for Medical Records Release Form

DATE: _____

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

Doctors name you are requesting to release records: _____
Address: _____
Contact Number: _____ Fax Number:_____

Please send a copy of my medical records to:

The Northwestern Specialist for Women
900 N. Kingsbury Suite 130- N
Chicago, IL 60610
Contact Number: 312-775-1100
Fax Number: 312-775-1111

Purpose or need for information: _____

Appointment scheduled _____

Medical records for the period (dates) from _____ to _____

Please be specific on which records are needed: _____

_____

I also understand that this Authorization is subject to withdrawal by me at any time in writing to the medical record contact person at this office 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 the Authorization, the institution named above will not release my health information. **If records from an outside physician is provided you will need to **re-request** those records from the physician. Per our office policy we will not release third party information**

Date: _____ Time: _____ Signature of the patient: _____

Date: _____ Time: _____ Signature of Parent/Legal Guardian/ Personal

Representative: _____

Thank you for your cooperation.

Created 7/12/08 SV