HIGHLAND PARK OB-GYN ASSOCIATES, LTD.
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CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I, _____, hereby give my consent to Highland Park OB-GYN Associates, Ltd., to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of _____.

I, _____, hereby give my consent to share all of my medical information to include all protected healthcare information, including mental health treatment, alcoholism treatment, and HIV/Acquired Immune Deficiency Syndrome (AIDS) records, Mental health treatment records, Alcoholism treatment records and Drug abuse treatment records with:

Name:_____ Relation to Patient: _____

Name:_____ Relation to Patient: _____

Where may we leave a message for you regarding your test results? Home ____ Cell ____ Work ____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian or Power of Attorney Date

If you are not the patient, please specify your relationship to the patient: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available in our office.

_____ _____
Patient Signature Date