Heart of Illinois Obstetrics & Gynecology
1302 Franklin Ave., Suite 2800, Normal, IL 61761 • 309-454-3456

Patient Authorization for Use & Disclosure of Protected Health Information and Notification of Test Results

I _____ give my permission to release my medical information and lab results to the following persons only:

Name	Relationship
_____	_____
_____	_____
_____	_____

Primary Care Physician _____
Do you want our office to notify you if results are normal? Yes ___ No ___
Phone number to contact you with your results: _____
Would you like messages to be left with results? Yes ___ No ___

Please note, if you are currently pregnant and your lab results are normal, results will be discussed at your next prenatal visit. Feel free to call the office if you desire to discuss your results prior to your scheduled appointment.

Please be aware that our office will contact you with all abnormal results. Please contact our office if you have not been notified of your test results within 14 days.

Print patient name: _____ Date of Birth: _____
Signature of patient: _____
Today's date: _____

This information will remain in effect, until revoked in writing, by patient.