AUTHORIZATION FORM TO ALLOW QUALIFIED INDIVIDUAL

DIANE L. OZOG, M.D., S.C.
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Phone: 630-652-0606 Fax: 630-652-9900

Date: ____________________

Authorization

I, ____ hereby authorize Diane L. Ozog, MDSC to use and/or disclose specific health and medical information for

____ ______________________
(Patient's Name) (Date of Birth)

To: ____ ______________________
(Qualified Individual as Personal Representative) (Relationship to Patient)

Unless revoked in writing, this authorization will expire in 1 year.

Signature: ____________________________________ Date: ______________________

Relationship to the patient: ______________________