

AUTHORIZATION FORM TO ALLOW QUALIFIED INDIVIDUAL

DIANE L. OZOG, M.D., S.C.

1288 Rickert Drive - Suite 100

Naperville, Illinois 60540

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: \_\_\_\_\_