

**PRAFULLA K. KONERU, M.D., S.C.**

OBSTETRICS, GYNECOLOGY & INFERTILITY

5 EXECUTIVE COURT, SUITE # 1

SOUTH BARRINGTON, IL 60010

PH: 847 382 8200 FAX: 847 382 8210

**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**REASON FOR RELEASE:**

- 2<sup>ND</sup> OPINION
- MOVING
- INSURANCE CHANGE
- OTHER: \_\_\_\_\_

\_\_\_TO / \_\_\_FROM:

\_\_\_FROM / \_\_\_TO:

**Prafulla K. Koneru, M.D.**  
**5 Executive Court, Ste 1**  
**South Barrington, IL 60010**

\_\_\_\_\_  
Physician Releasing

\_\_\_\_\_  
Address

Release:    \_\_\_ All Records  
              \_\_\_ Labs Only  
              \_\_\_ Ultrasound Reports  
              \_\_\_ Other

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**I HEREBY REQUEST THE INFORMATION STATED ABOVE**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\*This Authorization is effective for 90 days from date signed.