WEST SUBURBAN
WOMEN'S HEALTH

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, / / / , _____
(Name of patient) (Date of birth) (Phone number)

_____ authorize
(Street Address) (City) (State) (ZIP)

My records to be released FROM: _____
(Name)

FAX# - _____
(Street Address) (City) (State) (ZIP)

PHONE # -

My records to be sent TO: _____
(Name)

FAX# - _____
(Street Address) (City) (State) (ZIP)

PHONE # -

The type of information to be disclosed and date (check all that apply):

☐ The entire medical record excluding mental health treatment, alcoholism treatment, drug abuse treatment; and HIV / acquired immune deficiency syndrome (AIDS) records.

☐ Laboratory Reports: Specific report: _____

☐ X-ray / Ultrasound / Mammogram reports (Circle one requested): Specific date: _____

☐ Operative Notes: Specific Procedure: _____

☐ Genetic Testing Results: Specific test: _____

☐ Other: _____

- *To be disclosed, the following items must specifically be checked:*
- Mental health treatment records
- Substance abuse treatment records
- HIV / acquired immune deficiency syndrome (AIDS) records

My request is to release the above noted information for the time period from _____ **to** _____
(Date) (Date)

The purpose of the disclosure is: (check one)

____ CHANGING PHYSICIAN/LEAVING PRACTICE - - - EFFECTIVE DATE _____ (must include) _____ 2nd Opinion/Consult

____ Insurance Change ____Continuing Care with other provider - sharing results/records _____ Personal Use

____ Other (please specify reason) _____

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of the signature. Information included in this disclosure may be subject to re-disclosure by the recipient and may no longer be protected by law.
I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization.
I understand that in accordance with State and Federal confidentiality regulations, the information disclosed may include reference to or treatment of mental health, alcohol/drug abuse, and HIV **only** if indicated above. **I understand that there will be a fee charged to me to cover the cost of copying and sending my records.**
Expiration date or condition to expire: ☐ One year from date this form is signed
☐ Other: _____

_____ _____
(**Signature of person giving consent**) (**Date signed**) (**Witness**) (**Date signed**)

The signature is of the _____ Patient _____ Parent of Minor _____ Legal Guardian _____ Patient's Executor or Next of Kin

_____ Person authorized by Patient _____
(Specify relationship or authority to act)