WOMANCARE

Office Use Only	
Request Date:	_____
Date Mailed:	_____
Pick-up Date:	_____
Date Faxed:	_____
Paid:	$_____

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize WomanCare to release to:
(Name of Patient or Authorized Agent)

_____ _____ _____
(Name of Health Care Facility, Physician, Agency, etc.) *(Phone Number)* *(Fax Number)*

_____
(Street Address, City, State and Zip Code)

the following information contained in the patient record of _____
(Patient's Name)

born _____, residing at _____
(Birthdate) *(Street Address, City, State and Zip Code)*

- ☐ The entire medical record, ***including*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

Unless, the following items have been specifically checked:

- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- ☐ Laboratory Reports
- ☐ Operative Notes
- ☐ X-ray Reports/Ultrasound Reports/Mammography Reports
- ☐ Other: _____

The above information for the following period of time shall be released: From: _____ to _____
(Date) *(Date)*

The purpose(s) of the authorization is (are) _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____
(Date Request Completed)

Signed: _____ Date: _____

WomanCare attending Physician's Signature: _____

If you are not the patient, please specify your relationship to the patient: _____

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Palatine, IL 60067
(847) 221-4700 Fax: (847) 221-4796

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