WOMANCARE

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize _____
(N*ame of Patient or Authorized Agent)* *(Name of Health Facility, Physician, Agency, etc.)*

_____
(*Street Address, City, State and Zip Code)* *(Phone Number)* *(Fax Number)*

To release to:
WomanCare, P.C.

_____
(*Street Address, City, State and Zip Code)* *(Phone Number)* *(Fax Number)*

the following information contained in the patient record of _____
(Patient's Name)
born _____, residing at _____
(Birth date) *(Street Address, City, State and Zip Code)*

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

To be disclosed, the following items must specifically be checked:

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

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Arlington Heights, IL 60004
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Arlington Heights, IL 60005
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Buffalo Grove, IL 60089
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355 W. Northwest Highway
Palatine, IL 60067
(847) 221-4700 Fax: (847) 221-4796

455 S. Roselle Road ~ Suite 120
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814 E. Woodfield Road
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