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: ____

1051 W. Rand Road ~ Suite 101
Arlington Heights, IL 60004
(847) 221-4900 Fax: (847) 221-4996

216 S. Arlington Heights Road
Arlington Heights, IL 60005
(847) 221-4400 Fax: (847) 221-4465

15 South McHenry Road ~ 4th Floor
Buffalo Grove, IL 60089
(847) 221-4900 Fax: (847) 221-4996

21481 North Rand Road ~ 2nd Floor
Kildeer, IL 60047
(847) 221-4900 Fax: (847) 221-4996

1051 Perimeter Drive ~ Suite 150
Schaumburg, IL 60173
(847) 221-4300 Fax: (847) 221-4396