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Authorization for Release of Confidential Health Information

Patient name: _____ Date of birth:_____

Telephone: _____

Address: _____ Medical record # (office only): _____

I hereby authorize the protected health information regarding the above-named person to be exchanged to:
Person/Institution/Other:_____

Address: City/State/Zip:_____

Phone number: _____ Fax: _____

I authorize the release of information pertaining to the following time periods: From date(s): _____ To date(s): _____

The following types of information to be disclosed are as follows:

□ History and physical examination
□ Abstract (documents summarizing history)
□ Consultation reports
□ Diagnostic reports (labs, x-rays, etc)
□ Progress notes
|□ X-ray films □ Operative reports
□ Other:

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

□ HIV/AIDS related health information/records (410 ILCS 305/9)
□ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
□ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
□ Individual Genetic (not fetal) testing information/records (410 ILCS 513/30)

The purpose(s) of this authorization is (are):

_____

This authorization expires (date): _____. If not specified, this release will expire 1 year after the date of signature.

• 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 disclosure of my health information. Written revocation must be sent to the physician's office.

• I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Gynecological and Obstetric Associates, S.C. to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent:

_____

Signature of patient or legal guardian, or authorized agent:

_____ Date: _____

Relationship to patient: _____

Staff signature: _____ Date: _____