Women's Healthcare Group of Illinois

3 South Greenleaf, Suite A

Gurnee Illinois, 60031

847-244-0222

Outside Medical Records Release Authorization

(Requesting your records from another provider)

I, ______________________________ hereby authorize______________________________

Patient or legally authorized person physician/group

____

address phone/fax

to release the following information on:

Patient name: ______________________________ Birth date: __________________

Patient address: ____

Phone number: ________________________

Please check all information to be released:

□ Entire record set

□ Registration record

□ Laboratory reports

□ Imaging reports (ultrasound/mammogram)

□ Other ____

□ Problem list

□ Medication list

□ Physician notes

Dates of treatment: ____

Information shall be released (sent) to: **Women's Healthcare Group of Illinois**

3 South Greenleaf, Suite A

Gurnee, IL 60031

847-244-0222 847-244-7122 (fax)

1) I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status. □ **Include these records** □ **Do not include these records**

2) I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.

I authorize the following individuals to pick up my records:______________________________

(must bring picture ID)

Authorized signature: ______________________________ Date: ________________

Relationship to patient: □ Patient □ Legal guardian □ Parent □ Healthcare power of attorney

(Submit signed copy)

Staff Initials ____________