HEART OF ILLINOIS OB-GYN/Patient Authorization to Release Medical Information

Patient Name (Print) _____ Patient DOB _____

I authorize _____to use or release/disclose my health information as described below.

Name of Releasing Facility: _____
Address: _____

Phone: _____ Fax: _____

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent office visit
- ☐ Most recent pap smear/mammogram
- ☐ Lab results
- ☐ Mammogram
- ☐ Ultrasound, CT, MRI imaging reports – ***images not needed***
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other health care providers
☐ Transferring care

New Address (if relocating)

Address: _____ City: _____ State: _____ Zip: _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: Phone:
Address: Fax:

This authorization will expire twelve (12) months from the date on which it was signed.

_____/_____

Patient Signature (or Signature of Person Completing Form if Not Patient*) **Date**

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

The patient or personal representative must be provided with a copy of this form upon signing.
You may return this form to our office in person or via fax at 309.454.6977