

Women for Women

Authorization to release information to Women for Women

Patient Name _____ Birth date _____

Former Name _____ Daytime phone # _____

Information to be released from:

I hereby Authorize (Name of Organization): _____

Address _____

Street

City

State

Zip Code

Phone _____ Fax Number _____

To release the following information to: **Women for Women**
1302 Franklin Ave Suite 2200
Normal, IL 61761
Secure Fax: 309-888-9919

INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

___ All Medical records (including ultrasounds, mammogram, pap smear, laboratory, operative and pathology reports) From _____ To _____

___ Lab Results (specify) _____ From _____ To _____

___ Ultrasound Reports (specify) _____ From _____ To _____

___ Pathology Reports (specify) _____ From _____ To _____

___ Operative Reports (specify) _____ From _____ To _____

___ Other Records (specify) _____ From _____ To _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

___ Drug Abuse Diagnosis/Treatment From _____ To _____

___ Alcoholism Diagnosis/Treatment From _____ To _____

___ Mental Health Diagnosis/Treatment From _____ To _____

___ Sexually Transmitted Disease Diagnosis(including AIDS/HIV)/Treatment From _____ To _____

I have a right to inspect the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above-named institution (releasing records) will not refuse to treat me based on my agreement or disagreement to allow my health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation by me at any time in writing at the releasing site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date Signature of Patient/Legally Responsible Party Relationship to Patient if not Patient

EXPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an earlier date _____

WITNESS SIGNATURE

REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois Law Prohibits the redisclosure of any health information regarding HIV and mental health treatment without further patient authorization.