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

to release the following information to: Women for Women
1302 Franklin Ave. Ste 2200
Normal, IL 61761
SECURE FAX NUMBER 309-888-9919

TYPE OF INFORMATION TO BE RELEASED:

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_____

1. 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 id 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.