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www.womenshealthpractice.com

## Authorization Form for Release of Confidential Health Information

I, \_\_\_\_\_, hereby authorize **Women's Health Practice** to release to:  
*(Name of Patient or Authorized Agent)*

\_\_\_\_\_  
*(Name of Health Care Facility, Physician, Agency, etc.)*

\_\_\_\_\_  
*(Street Address, City, State and Zip Code)*

the following information contained in the patient record of:

\_\_\_\_\_ born \_\_\_\_\_  
*(Patient's Name)* *(Birthdate)*

residing at:

\_\_\_\_\_  
*(Street Address)*

\_\_\_\_\_  
*City, State and Zip Code)*

- The entire medical record, **excluding** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records, pregnancy termination records.

**To be disclosed, the following items must specifically be checked:**

- Mental Health Treatment Records  
 Alcoholism Treatment Records  
 Drug Abuse Treatment Records  
 HIV/Acquired Immune Deficiency Syndrome (AIDS) Records  
 Pregnancy Termination Records  
 Laboratory Reports  
 X-ray Reports  
 Operative Notes  
 Other: \_\_\_\_\_

The above information for the following period of time shall be released:

From: \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date)

The purpose(s) of the authorization is/are: \_\_\_\_\_

\_\_\_\_\_

***The medical records fee is as following: handling fee, \$.77 for 1-25 pages, \$.51 for 26-50 pages, or \$.26 for 51 and over pages. Illinois Law prohibits charges that exceed the above.***

I understand that I have the right to inspect and obtain a copy of 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 WHP 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 disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on \_\_\_\_\_ (Date).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_

\_\_\_\_\_