



2125 South Neil Street
Champaign, IL 61820-7266
(217) 356-3736
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 \$20.00 plus \$0.93/page for 1-25 pages, \$0.62/page for 26-50 pages and \$0.31/page 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: _____
