



Advanced Women's
Healthcare

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Obstetrics | Gynecology | Urogynecology | Minimally Invasive Surgery | Infertility

Authorization for Release of Confidential Health Information

1. Individual Information:

Printed Name of Patient _____ Date of Birth _____

Address _____

Phone Number _____

2. Information may be disclosed by:

Name of Organization or person releasing information: **Advanced Women's Healthcare**

Address: **2111 E Oakland Ave Suite B Bloomington, IL 61701**

Phone Number: **309-808-3068** Fax Number: **309-808-3072**

3. Information may be disclosed to:

Name of Organization or person receiving information _____

Address _____

Phone Number _____ Fax Number _____

4. What information do you want disclosed? (Choose ONE option, copy fees may apply)

- Information from the most recent 2 years of visits
- All information from date ___/___/___ to date ___/___/___
- Information regarding specific treatment, condition, or other (specify):

5. Why are you asking for this health information to be released? (Choose ONE option)

Attorney Insurance Doctor Medical Leave Personal Other (specify) _____

6. Authorization: The medical information to be released as specified above may include any of the following information as it pertains to the request: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. By my initials and signature, I give my specific authorization for this information to be released. _____ **(initial)**

Mental Health Developmental Disabilities Alcohol/Substance Abuse HIV/AIDS Other _____

7. Expiration:

 This authorization expires in 90 days from the date signed or on the date or event indicated here:

8. Signature: _____ **Date:** ___/___/___

9. Signature of Witness: _____ **Date:** ___/___/___