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 _____

Address _____

Phone Number _____ Fax Number _____

3. Information may be disclosed to:

Name of Organization or person receiving 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

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: _____ /_____ /_____