Patient Authorization to Release Medical Information

Obstetrics & Gynecology II, Ltd.
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Patient Name_____ Maiden Name_____ SS#_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ FAX#_____

C) For the purpose of:

_____ Continuity of Care/Transfer of Care

_____ Self/Personal Copy

_____ Insurance

_____ Work Comp

_____ Litigation

_____ Disability

_____ _____

Date Range_____ to_____

- ☐ Entire Record
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Physicians Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____**Subject to Fees

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

***PLEASE READ** Fee Information: We reserve the right to charge the fee schedule as set by the State of Illinois: $25.99 handling fee, $0.97 per page for the first 25 pages, $0.65 for pages 26-50 and $0.32 for pages 51+. By signing this authorization, you are agreeing to pay our office for your medical records.