

Women's Healthcare Group of Illinois and The Women's Wellness Group

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Ph. (847) 244-0222 (Illinois)/340-713-0330 (Virgin Islands) Fax (847) 244-7122 (Illinois)/ (340)-713-0335 (Virgin Islands)

Medical Records Release Authorization

I, _____ hereby authorize **Women's Healthcare Group of Illinois and/or The Women's Wellness Group** to release the following information on:

Patient name: _____ Birth date: _____

Patient address: _____

Phone number: _____

Please check all information to be released: (Allow a minimum of 5 business days for copying)

- | | |
|---|--|
| <input type="checkbox"/> Entire record set | <input type="checkbox"/> Problem list |
| <input type="checkbox"/> Registration record | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Physician notes |
| <input type="checkbox"/> Imaging reports (ultrasound/mammogram) | |
| <input type="checkbox"/> Other _____ | |

Dates of treatment: _____

Information shall be released (sent) to: _____

Address: _____ Fax: _____

Phone number: _____

Purpose for release of records:

- 2nd Opinion/consult Moving Changing physicians For attorney Personal use

Other: _____

· *I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status. Include these records Do not include these records*

· *I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.*

Fees:

I understand that the State of Illinois Code of Civil Procedure 735 ILCS 5/8-2001(d) authorizes medical providers to charge a fee for record copying. I understand that the fee may include a handling charge (*effective 2015*) of \$26.58 plus up to \$1.00 per page for the first 25 pages, \$.66 per page for 26-50 pages, and \$.33 per page thereafter plus the cost of postage. We require payment before records are released. Federal privacy rules require that requests for copies of health records must be responded to no later than 30 days after receipt of the written request. If we are unable to meet your request to copy records within 30 days we will notify you in writing.

I authorize the following individuals to pick up my records: _____

(must bring picture ID)

Authorized signature: _____

Date: _____

Relationship to patient: Patient Legal guardian Parent Healthcare power of attorney
(submit signed copy)

Staff Initials _____