

Fox Valley Women's Healthcare  
901 Center St, Suite 102  
Elgin, IL 60120  
847-741-7990 847-741-8099 (fax)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize \_\_\_\_\_ to release my medical records to:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**From the medical record of (patient):**

Date Last Seen: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**To be released:**

Entire Medical Record

Operative Report

Laboratory Results

Emergency Room Report

X-Ray Report

Discharge Summary

Consultation Report

EKG

History & Physical

Ultrasound Report

Progress Notes

Other (please specify)

**The purpose of this release of information is:**

Relocation  2<sup>nd</sup> Opinion  Insurance Change (list new insurance): \_\_\_\_\_

Dissatisfaction (Please specify): \_\_\_\_\_

- I fully understand my medical record information, in connection with the treatment date(s) stated above, may contain AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus), mental health, developmental disabilities, and/or substance abuse test results or information. The medical information disclosed is protected under State and Federal law and this Privileged and confidential information may be disclosed only on my authorization, except as expressly required as law. Only such medical information believed necessary for the purpose expressed above, shall be released or disclosed. Disclosure of this information carries the potential for an unauthorized re-disclosure & the information may not be protected by federal confidentiality rules.
- I understand that I have the right to inspect and copy any information that is disclosed and can revoke this at any time in writing.
- I understand that if I refuse to consent to the release of information, my medical record information will not be released and denial of insurance reimbursement may occur.
- This authorization will expire on this particular date: \_\_\_\_\_. If no date is written, this authorization will expire in 6 months from the date above.

I  **do**  **do not** specifically consent to transmission of my medical records via a facsimile (fax) machine.

Signature: \_\_\_\_\_  
Parent/Guardian (if under age 17): \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_