

Women's Healthcare of Illinois

9730 South Western Ave., Ste. 100
Evergreen Park, IL 60805
Phone (708) 425-1907 ♦ FAX (708) 422-4253

9601 W. 165th St., Ste. 2
Orland Park, IL 60467
Phone (708) 349-7310 ♦ FAX (708) 349-6916

Outside Medical Records Release Authorization (requesting your records from another provider)

I, _____ hereby authorize _____
Patient or legally authorized person *physician/group*

address *phone/fax*

to release the following information on:

Patient name: _____ Birth date: _____

Patient address: _____

Phone Number: _____

Please check all information to be released:

- | | |
|---|--|
| <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 to: **Medical Records Department
Women's Healthcare of Illinois
9730 S. Western Ave. Ste 100
Evergreen Park, IL 60805
708-425-1907 708-422-4253 (fax)**

- 1) 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**

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

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)