

# Women's Healthcare of Illinois

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## Medical Records Release Authorization

I, \_\_\_\_\_ hereby authorize **Women's Healthcare of Illinois** 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: \_\_\_\_\_

Purpose for release of records:

- 2<sup>nd</sup> Opinion/consult    Moving    Changing physicians    For attorney    Personal use  
Other: \_\_\_\_\_

- 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.*

### Fees:

I understand that the State of Illinois (*735 ILCS 5/8-2001 Code of Civil Procedure*) authorizes medical providers to charge a fee for record copying. I understand that the fee may include a handling charge (*effective 01-20-2008*) of \$23.78 plus up to \$.89 per page for the first 25 pages, \$.59 per page for 26-50 pages, and \$.30 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)*