Authorization to Disclose Protective Health Information

Date:_____ Printed Patient Name:_____

Address:_____

City:_____State:_____Zip:_____Telephone:_____

Date of Birth:_____ Date Information needed:_____

I hearby authorize _____Fax:_____

to release the protected health information indicated below on the above named individual to:

(Provider Name) Midwest OB/GYN & Midwifery

Address: 800 Biesterfield Rd. City: Elk Grove Village State: IL Zip: 60007

Telephone: 847-357-1144 Fax847-357-9449

(If no prior notice of revocation is received, this authorization will expire 90 days from the date signed below)

For the following purpose: ( ) Health Care Facility ( ) Legal Purpose ( ) Personal Use
For treatment date(s) or service: _____
Information to be disclosed:
( ) Abstract chart (includes Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Operative reports & Diagnostic tests)
( ) Entire medical record ( ) History and Physical ( ) Consultation
( ) Operative Report ( ) Discharge Summary ( ) Emergency Room
( ) Pathology Report ( ) Laboratory Results ( ) Radiology Reports
( ) Rehabilitation Services ( ) Other _____

I understand that:

- The information in my health record many include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and treatment for alcohol and/or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility benefits.

X_____ _____ _____ _____

Signature of patient or legal representative **Date** **Signature of Witness** **Date**

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient:
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received:_____ Date completed: _____ MR# _____
When applicable, the identity of the Legal Representative will be verified by the following documentation and established that in his/her capacity, the above named individual is authorized to act on behalf of the patient.
( ) Driver's License ( ) Picture ID ( ) Legal Guardian ( ) Court appointed Legal Guardian ( ) Power of Attorney ( ) Executor of Estate
( ) Other_____