AUTHORIZED REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____

SSN (Last Four Digits Only): _____

I hereby authorize, _____
(name of physician / facility which holds this information)

to release my protected health information (PHI) to:

☐ Myself

☐ To the following: TERESA TAM, MD FACOG
ALL FOR WOMEN HEALTHCARE, SC
2800 N. SHERIDAN ROAD, SUITE 205N
CHICAGO, ILLINOIS 60657
VOICE: 773-904-8641 • **FAX: 872-888-1206**

Purpose of Release:

☐ Transfer of care
☐ Application for insurance
☐ Insurance claim
☐ Personal use
☐ Legal purposes
☐ Other: _____

Information to be released:

☐ History & Physical Exams
☐ Discharge Summary
☐ Operative Reports
☐ Progress Notes
☐ Consultations/Evaluations
☐ Outpatient Clinic Records
☐ Laboratory Reports
☐ Emergency Medicine Reports
☐ Radiology & other diagnostic reports
☐ Genetic Testing Information
☐ Pathology Reports

I request my records as a: ☐ PRINTED copy ☐ DIGITAL COPY (CD-ROM)

I understand information released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date here (_____).

Patient Signature: _____ Date: _____

Printed name: _____