OBSTETRICS AND GYNECOLOGY CARE ASSOCIATES, S.C.
1414 WOODBINE RD | BLOOMINGTON, IL 61704
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Authorization for Release of Confidential Health Information

1. **Individual Information:**

Printed Name of Patient	Date of Birth		Phone Number
Street Address		**Apt / Suite**	**City, State, Zip**

2. **Information may be disclosed by:**

_____
Name of organization or person releasing information

_____
Street Address, City, State, Zip

__(____)_____ __(____)_____
Daytime Phone Fax

3. **Information may be disclosed to:**

_____
Name of organization or person releasing information

_____
Street Address, City, State, Zip

__(____)_____ __(____)_____
Daytime Phone Fax

4. **What information do you want disclosed?** **(Choose ONE option, copy fees may apply)**

- ○ Information from the most recent 2 years of visits
- ○ All Information from date: ____/____/____ to date: ____/____/____
- ○ Information regarding specific treatment, condition, or other (specify):
  _____

5. **Why are you asking for this health information to be released?** **(Choose ONE option)**

Attorney Insurance Doctor Medical Leave Personal Other (specify) _____

6. **Authorization:** Information released may include any of the following: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. By my initials and signature, I give my specific authorization for this information to be released. _____ **(initial)**

7. **Expiration:** This authorization expires 90 days from the date signed or on the date or event indicated here:
_____

8. **Signature:** _____ **Date:** ____/____/____
(Patient, Guardian, or Authorized Representative)