OBSTETRICS AND GYNECOLOGY CARE ASSOCIATES, S.C.
1505 EASTLAND DRIVE, SUITE 500 | BLOOMINGTON, IL 61701
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WWW.OBGYNCARE.COM

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 receiving 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: The medical information to be released as specified above may include any of the following information as it pertains to the request: 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)**

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol/Substance Abuse ☐ HIV/AIDS ☐ Other_____

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

8. Signature: _____ Date: _____/_____/_____
Please indicate your relationship (circle one) : Patient Parent /Guardian Authorized Representative

9. Signature of Witness: _____ Date: _____ Month/Day/Year