OBSTETRICS AND GYNECOLOGY CARE ASSOCIATES, S.C.
1414 WOODBINE | 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. Expiration: This authorization expires 90 days from the date signed or on the date or event indicated here, however no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form, I understand this authorization is voluntary. I understand that if the recipient of this information is not a heath plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.

6. Why are you asking for this health information to be released?

❑Legal ❑Insurance ❑ Continuing Care ❑ Medical Leave ❑ Personal

❑ Transfer of Care to _____ ❑Other (specify) _____

7. Sensitive Medical Information to be released and Minor Patients 12 – 17 YEARS OF AGE

I understand that the records requested above may contain sensitive medical information that requires my specific consent in order to be released. I specifically authorize the release of the following sensitive medical information.

Please note that the following medical information of a Patient 12 - 17 years of age (Minor Patient) is restricted as follows: Drug/Alcohol use, AIDS.HIV, or Birth Control / Sexually Transmitted Disease(s) / Sexual Assault, as well as any health information generated as a result of the Minor Patient's independent legally-authorized consent to treatment, requires the Minor Patient's signature release.
Mental health or developmental disabilities information is available after the Minor Patient's signature has been witnessed or the Minor Patient's parent or guardian's signature has been witnessed, provided the Minor Patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor Patient's parent or guardian.

- ❑ Child Abuse / Neglect
- ❑ Abuse of an adult with a Disability
- ❑ Pregnancy
- ❑ Birth Control
- ❑ Mental Health / Developmental Disabilities
- ❑ Sexual Assault
- ❑ Genetic Testing
- ❑ Drug / Alcohol Use
- ❑ Aids / HIV

_____ _____ _____
Signature of Patient or Authorized Representative Relationship Date

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

_____ _____
If signed by Other than the Patient: PRINT Patient Representative's Name **Phone Number**

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

Office Use Only
Received by:_____
Date:_____

Processed /Completed by:_____
Date:_____