WHC

WOMEN'S HEALTH CONSULTANTS

Providing Hope • Fulfilling Dreams

Authorization to Release Medical Information

Patient Name: _____ **DOB**: _____

Address: _____

_____

Phone: _____

I request and authorize _____ *to release medical information*
Name of Physician

from my medical record and send to the following physician:

Name of Physician: _____

Address of Practice: _____

_____

Phone: _____ **Fax**: _____

I authorize you to release my entire medical record to the physician named above subject to the following limitations, if any.

_____ No limitations, send the entire record

_____ Limitations on the information related to the following:

_____ HIV/AIDS, Sexually Transmitted Diseases

_____ Substance Abuse and subsequent treatment

_____ Mental Health Treatment

This authorization will automatically expire **one year from the date signed**. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ **Date** _____

***Please note, there are fees associated with either sending your medical records from Women's Health Consultants to another physician's office or requesting a copy for your own records. We follow the Federal HIPAA and Illinois State Guidelines to determine the pricing for your records.**

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