AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name (Please Print) ____ DOB ____ / ____ / ____

Patient ID#__________ Current Phone Number______________________ Date of Request ____ / ____ / ____

I authorize and request the release of information from my health records from:

Agency / Facility / Person: ____

Address: ____ Suite: ________

City: _________________________ State: ________________ Zip Code: ________

Phone: (_____) _______________ Fax: (_____) _______________

TO: **Fox Valley Women & Children's Health Partners**
3310 W. Main St. Ste 200, St. Charles, IL. 60175
Phone: 630-897-6044 / Fax: 630-897-0180

The following information should be released:

[ ] Immunization Records
[ ] Ultrasound Reports
[ ] History and Physicals
[ ] Delivery Summary
[ ] Growth Charts
[ ] Mammogram Reports
[ ] Progress Notes
[ ] Prenatal/Lab Flow sheet
[ ] Asthma Action Plan
[ ] Laboratory Pathology Reports
[ ] Procedure /Surgery Reports
[ ] Transferred in Records
[ ] Other (specify date of service): ____________________________________

The following items must be <u>checked and initialed**</u> to be included in the use and/or disclosure of other health information: **

[ ] ____ HIV/AIDS related treatment
[ ] ____ Mental Health
[ ] ____ Sexually Transmitted Diseases (STDs)
[ ] ____ Drug / alcohol diagnosis, treatment/ referral

Reason for disclosure:

[ ] Sharing with other health care provider as needed
[ ] Insurance processing
[ ] Legal Reasons
[ ] Other (Specify) ____
[ ] Transfer of Care / Continuing Care
[ ] Personal Use
[ ] School / Camp / Sports

I am aware that the above is privileged information and that my request and attested to by my signature that I waive this privilege and hold Fox Valley Women's Health Partners, its owners and employees, personally and corporately, harmless from any and all liability that might be associated with the release of this information. This Authorization may be revoked at any time, provided the revocation is a properly executed written document delivered to the Medical Records Department (address above). I understand that once the information is released, it may be released again by the recipient and federal and/or state privacy laws may not protect the subsequent release. I understand authorizing the release of information identified above is voluntary and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization with expire on the following date or event:____

If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

Signature: ____ Date: ___________

If the Patient is under 18 years of age, unless that Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent , guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

For Office Use Only: [ ] MAIL [ ] Pick-up (date________) [ ] Fax [ ] RUSH Appt. Date_____________

# Pages	Date	Method	Initials	Tracking number

Reviewed by (Sign & Print Name)____ **Date**____ / ____ / ____