

**AUTHORIZATION FORM / RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_

Patient's Name DOB Telephone #

Hereby authorize: \_\_\_\_\_

To Release the following information:

Time Period: From: \_\_\_\_\_ To: \_\_\_\_\_

The entire medical record, excluding mental health provider, alcoholism, drug abuse, and positive HIV/acquired immune deficiency syndrome (AIDS) treatment records

Mental Health Provider Records

Alcoholism Records       Drug Abuse Records

Positive HIV/Acquired Immune Deficiency Syndrome (AIDS) Treatment Records

Laboratory Reports       Xray / CT / MRI / Ultrasounds

Operative Notes

Other: \_\_\_\_\_

To: Northwestern Women's Health Associates / 312 – 440 – 9400  
680 N. Lakeshore Dr., Suite 1200. Chicago, IL 60611

The purpose(s) of the authorization is (are): \_\_\_\_\_

This authorization expires in 90 days.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-describe information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_