Premier Women's Health Associates, SC.

Release Medical Records Form

Patient Name_____ Date of Birth_____

Home Phone ( )_____ Cell Phone ( )_____

Address _____

City _____ State _____ Zip_____

I, here by, request my medical records be released to the following:

Physician/Facility/Patient _____

Address_____ City _____ State _____ Zip _____

Phone ( )_____ Fax ( )_____

INFORMATION TO BE RELEASED

___Recent Labs and notes ____ Entire Record ____ Other (such as time period needed) _____

PUROSE OF DISCLOSURE

_____ Personal ____Insurance ____ Changing Physicians ____ Consultation/2nd opinion ____ Attorney ____ Other _____

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS/, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **EXCLUDE** the following information from the records released *(please initial)*

_____ Drug/Alcohol abuse/treatment and diagnosis _____ sexually transmitted disease _____ HIV/AIDS diagnosis/treatment/testing
____Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). This authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year after date of signature. I understand that I have the right to REVOKE this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: _____. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under **HIPPA Privacy Laws**. Records from HEALTHCARE PROVIDERS OTHER THAN PREMIER WOMEN'S HEALTH, will not be disclosed.

By signing below, I understand that according to the rules set by the Illinois State Board of Medical Examiners, Premier Women's Health has 30 business days form this date was received, to provide me with an exact copy of the above requested information within my medical record. I am also aware that a fee may apply to this request and is SOLELY the responsibility of the patient

Signature: _____ Date _____
(Parent, guardian or authorized representative)

NOTICE: The information contained in this transmission is privileged and confidential. It is solely for the use of the recipient, named above; you are hereby notified that any dissemination, distribution, copying or disclosure of the contents of this transmission is prohibited. If you have received this transmission in error, please notify us immediately

PREMIER WOMEN'S HEALTH ASSOCIATES

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