



W o m e n M a k i n g H e a l t h C a r e A c c e s s i b l e

## Medical Records Release/Request Form

(Check One)

**Release** \_\_\_\_\_ Releasing information from us to you or your provider

**Request** \_\_\_\_\_ Requesting information from another provider to us

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

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_

I authorize the Chicago Women's Health Center to **release/request** (*circle one*) the following:

Information Requested \_\_\_\_\_

Purpose of Request \_\_\_\_\_

Duration of Authorization \_\_\_\_\_

To/From (*circle one*) Name \_\_\_\_\_

Address \_\_\_\_\_

Phone and Fax: \_\_\_\_\_

*(It is important that you give as much contact information as you can, especially the provider's name and phone.)*

- I understand that this authorization shall be valid through \_\_\_\_\_ (date), but that I may revoke it **in writing** at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may **not** be re-released to any other person or organization without my written consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_