CHICAGO WOMEN'S HEALTH CENTER

COMPASSIONATE - COLLABORATIVE - COMPREHENSIVE

Medical Records Release Form

This form allows us to send your records to another provider or individual.

Date:_____

Client Name:_____ Date of Birth:_____

Address:_____

Phone:_____

I authorize the Chicago Women's Health Center to release the following:

___Specific Lab Reports:_____

___All Lab Reports

___Specific Visit Notes:_____

___Complete Medical Record

___Other:_____

Date(s) of records to be released:_____ through_____

Records Released To:

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 from _____(date) 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 the release of information may not be re-released to any other person or organization without my written consent.*

Signature:_____ Date:_____