CHICAGO WOMEN'S
COMPASSIONATE - COLLABORATIVE - COMPREHENSIVE
HEALTH CENTER

Medical Records Release to Self Form

We need your permission to release any records from our facility. By signing this form you authorize Chicago Women's Health Center to release your records to you. A separate form is required to release your records to a third party.

- **This authorization is ongoing.**
- **Your records or results will only be sent to you if you request them.**
- **Email is not a secure way to send protected health information. We will only communicate with you via email if you authorize us to do so below.**
- **If you request records to be mailed to a different address (mail, email or fax) than the one listed below or the one in your most recent medical record, you will need to submit an updated form with that information.**

Name:________________________Date of Birth:___________

Address:____
Street Apt# City State Zip code

Phone:___________________ Fax: ___________________

Email: ____

I authorize my records to be released to myself through the following methods (Please initial all that apply):

______ In person
______ By mail
______ By fax
______ By email

Signature:_________________________________Date:_____________