



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

Release _____ **Request** _____ (**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:** _____