



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 to Self Form

In order to release any of your records or results from our facility, we are required by law to have your written permission to do so. This helps to protect your privacy. While maintaining your privacy, we also want to make it easy for you to get access to your own health records.

This form will allow us to release any of your records to YOU, when you request them.

Date: _____ **Date of Birth:** _____

Name: _____

Address: _____
Street Apt# City State Zip code

Phone: _____ **Fax:** _____

- *I authorize the Chicago Women's Health Center to release any of my records to myself.*
- *I understand that this is an ongoing authorization.*
- *I understand that my records or results will only be sent to me if I request them.*
- *I understand that this does NOT give permission to release my records to anyone else besides myself (including other providers). (In order to send your records to someone other than yourself, you will need to fill out a separate release form.)*

Signature: _____ **Date:** _____

Witnessed by: _____ **Date:** _____