Lincoln Park Gynecology/
Pelvic Rejuvenation Center

Authorization for Release of Information

Patient Information: Print name:_____ Date of Birth: _____

SS#:_____ Maiden or prior name: _____

Please release my healthcare information from:

Name of Facility/Provider:

_____

Address: _____

City/State/Zip _____

Phone Number: _____

Please send my healthcare information to:

Name designated recipient:

_____

Address: _____

City/State/Zip _____

Phone Number: _____

Information to be released

®The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
®All medical records
®Specific information (please specify)

Purpose for which disclosure is being made:

Sharing with other health care providers
Legal investigation
Other: _____
Personal use
I am transferring my care to a new health care provider

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and Lincoln Park Gyn, SC is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posed at the facility where your information is begin released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Lincoln Park Gyn, SC_____will continue to provide one complimentary copy of a patient's medical record to another health care provider (exceptions, of course, for emergency situations). Our charges to release records to a patient or relative are calculated according to Illinois Law. If the copies are made by our outside source, you will be billed according to their fees. This fee must be paid before your records can be released.

I understand that I may be charged at the rates, shown above for the copies of the records I have requested and for postage, if needed. I agree to pay the total charges upon receipt of the copies.

Signature: _____ Date: _____

(Patient, Guardian*, Authorized Representative* - * Please provide documents to prove authority to sign on behalf of the patient)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED

Updated: 03.31.2014