PERSONAL WOMEN'S HEALTH CARE, S.C.

800 Biesterfield Rd, Ste #106 Wimmer Medical Building
Elk Grove Village, IL 60007
847-981-8866-Phone
847-981-5580 Fax

1435 N Randall Rd, #310
Elgin, IL 60123
847-981-8866-Phone
847-981-5580-Fax

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME ______________________________ BIRTH DATE ______________
Patient's Phone # ______________________________
MAIDEN NAME IF APPLICABLE ______________________ SS# ______________

I AUTHORIZE PERSONAL WOMEN'S HEALTH CARE, S.C. TO RELEASE MY MEDICAL RECORDS TO:

NAME: ____

ADDRESS: ____
CITY STATE

Please send the following specific information concerning my illness and/or treatment in your facility:

[ ] All records within the last 5 years
[ ] All records to include sensitive information such as HIV (AIDS virus),substance abuse, etc.
[ ] Records of HIV disease, mental illness, drug/alcohol abuse, and/or sexually transmitted disease treatment
[ ] X-rays / Films
[ ] Other: (indicate specific illness, procedure, date(s) of treatment, etc.) ______________

REASON FOR REQUEST:

[ ] Personal	[ ] Transfer of Care	[ ] New Insurance	[ ] Life Insurance
[ ] Legal Review	[ ] Disability	[ ] Moving	[ ] Second Opinion

[ ] Other, (please explain) ______________________________

I hereby consent to the release of the above information. You are authorized to release to the person or entity above all information or medical records relating to diagnosis, testing or treatment for such disease(s) as specified above. I understand that such information cannot be released without my informed consent. Expires in 90 days.

I hereby release Personal Women's Health Care, S.C. from all legal responsibility that may arise from this release of information.

I understand that there is a fee for copying my medical records. I have authorized and agree to pay per page fee of $0.92 cents (for pages 1-25), $0.61 cents (for pages 26-50), and $0.31 cents (for pages 51+) per public act 92-228 for transfer of records to cover copying and mailing.

______________________ ______________________
Date Signed Patient's Signature

______________________ ______________________
Witness Parent or Legal Guardian Signature

PLEASE ALLOW UP TO 2 WEEKS FOR PROCESSING

6/4/15

ZIP