

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, Suite #310
Elgin, IL 60123
847-981-8866-Phone
847-981-5580-Fax

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME _____ BIRTH DATE _____

MAIDEN NAME IF APPLICABLE _____ SS# _____

I AUTHORIZE: _____
TO RELEASE MY MEDICAL RECORDS TO:

PERSONAL WOMEN'S HEALTH CARE, S.C.
800 Biesterfield Rd Ste 106 Wimmer Medical Building
ELK GROVE VILLAGE, IL 60007
PHONE: 847-981-8866
FAX: 847-981-5580

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.

Date Signed

Patient's Signature

Witness

Parent or Legal Guardian Signature

PLEASE ALLOW UP TO 2 WEEKS FOR PROCESSING

6/4/15
