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Authorization Form for Release of Confidential Health Information

I, _____ , hereby authorize
(Name of Patient or Authorized Agent)

☐ Thrive OB & Women's Wellness to **RELEASE TO**

_____
(Name)

_____
(Street address)

_____
(City, State and Zip Code)

_____
(Phone #) (Fax#)

☐ **INFORMATION FROM**

_____
(Name)

_____
(Street address)

_____
(City, State and Zip Code)

_____
(Phone #) (Fax #)

TO BE RELEASED TO:
THRIVE OB AND WOMEN'S WELLNESS
27750 W HIGHWAY 22 SUITE 120
BARRINGTON, ILLINOIS 60010
FAX: 847-277-0505

The following information contained in the patient record of _____ born _____
(Patient's Name) (Date of birth)

Residing at _____
(Street address, City, State and Zip Code)

Home phone number _____ Cell phone number _____

- ❑ The entire medical record, including mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

To be excluded, the following items must be specifically checked

- ❑ Mental Health Treatment Records
- ❑ Alcoholism Treatment Records
- ❑ Drug Abuse Treatment Records
- ❑ HIV/Acquired Immune Deficiency Syndrome AIDS records

- ❑ Other: _____

The above information for the following period of time shall be released:
From_____ to_____
(Date) (Date)

The purpose (s) of the authorization is (are) _____

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that I will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on wither I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that is authorization is valid until it expires unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use of disclose my health information. Written revocation must be sent to the physician's office.

Signed _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____

PLEASE NOTE: THERE MAY BE A CHARGE FOR RELEASE OF RECORDS. PLEASE CALL THE OFFICE FOR QUESTIONS REGARDING THIS APPLICABLE FEE.