CHICAGO
women's
HEALTH GROUP

Consent for Release and Use of Confidential Information

I, _____, hereby give my consent to _____
(Name of patient or authorized agent) *(Name of releasing office)*

_____
(Address, phone, or fax number of releasing office)

To release or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information and records contained in the patient record of:

_____ _____ _____
(Patient's name) *(Date of birth)* *(Phone number)*

_____
(Patient's current address)

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Reason for Patient Health Information Release: _____

- ☐ The entire medical record, ☐ excluding ☐ including mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports
- ☐ Office Notes
- ☐ Pregnancy Notes
- ☐ Other

Please send copies of the above patient health information to:

TO: Chicago Women's Health Group
211 E. Chicago Ave, Chicago Il, 60611 Suite 1200
Fax: 312-943-0284
Attn:_____
(Provider name)

I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent.

Patient Signature:_____ **Date:** _____

- ☐ **You have the right to revoke this consent at any time with written notice.**