



**Medical Records Release Form**

*This form allows us to send your records to another provider or individual.*

**Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

***I authorize the Chicago Women's Health Center to release the following:***

- \_\_\_ Specific Lab Reports: \_\_\_\_\_
- \_\_\_ All Lab Reports
- \_\_\_ Specific Visit Notes: \_\_\_\_\_
- \_\_\_ Complete Medical Record
- \_\_\_ Other: \_\_\_\_\_

Date(s) of records to be released: \_\_\_\_\_ through \_\_\_\_\_

***Records Released To:***

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone and Fax:** \_\_\_\_\_

*(It is important that you give as much contact information as you can, especially the provider's name and phone.)*

- *I understand that this authorization shall be valid from \_\_\_\_\_ (date) through \_\_\_\_\_ (date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.*
- *I understand that I have the right to inspect and copy the information to be released.*
- *I understand that the release of information may not be re-released to any other person or organization without my written consent.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_