CHICAGO women's HEALTH GROUP

Consent for Release and Use of Confidential Information

I, _____, hereby give my consent to _____
Patient's Name or Authorized Agent *Name of Releasing Office*

_____
Address and Telephone 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* *Telephone 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:

Attn: _____
Chicago Women's Health Group
211 E. Chicago Avenue, Suite 1200
Chicago, IL 60611-2697
Fax (312) 943-0284

Other_____
Address _____
_____
Phone _____ Fax _____

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

_____ _____
Patient's Signature Date

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