**Central Illinois Obstetrics & Gynecology**
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PT ID #_____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ (_____)
MAIDEN OR OTHER NAME

Patient DOB: _____ SSN:___/___/___ PHONE #: (___)_____

Current Address:_____/_____/___/_____
STREET CITY STATE ZIP CODE

Legal Guardian: _____ X_____
(IF APPLICABLE) PRINT GUARDIAN NAME HERE WHEN APPLICABLE YOUR SIGNATURE HERE (or GUARDIAN'S WHEN APPL)

I authorize Dr. Weaver, M.D., S.C. to **release/obtain** my protected health information, specifically:
(circle one)

☐ **ALL MEDICAL RECORDS** – (ultrasounds, mammograms, pap smears, labs, operative notes, pathology reports).

| | OTHER REPORTS: | DATE OF REPORT: | DETAILS OF RECORD BEING REQUESTED |
|---|---|---|---|
| ☐ | LAB RESULTS | _____ | _____ |
| ☐ | ULTRASOUND REPORTS | _____ | _____ |
| ☐ | PATHOLOGY REPORTS | _____ | _____ |
| ☐ | OPERATIVE REPORTS | _____ | _____ |
| ☐ | OTHER REPORTS | _____ | _____ |

PLACE AN 'X' IN ONE OF THE CHOICES BELOW AND COMPLETE ALL NECESSARY INFORMATION SO WE MAY RELEASE OR OBTAIN YOUR MEDICAL INFORMATION:

☐ **OBTAIN MY MEDICAL RECORDS FROM:** **OR** ☐ **RELEASE MY MEDICAL RECORDS TO:**

DR'S OFFICE/or *SELF* _____
ADDRESS: _____
(City, St., Zip) _____
(Office Phone)(___) _____ (Fax#)(___) _____

**CURRENT FEE DUE FOR THE REPRODUCTION AND DISBURSEMENT OF YOUR MEDICAL RECORDS IS $15.00.**
**It is this office's decision as to what manner of disbursement will be utilized to send or obtain your records.**

**********FOR OFFICE USE ONLY**********

Patient Release information received by: _____ Date: _____

Payment for records NOT ACCEPTED/ACCEPTED: CASH/CREDIT CARD/CHECK (#_____) $_____

Patient Information sent by:_____ Date: _____ via: _____
EMPLOYEE NAME FAX / MAIL / TUBE/ HANDED TO