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Phone: (309) 451-9595
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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**) DATE:

I authorize Central Illinois OB/GYN 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**