Women's Healthcare Group of Illinois and The Women's Wellness Group
25 Tower Court, Suite B 890 Garfield Ave, Suite 203 4504 Estate Diamond, Suite 4
Gurnee, Illinois 60031 Libertyville, Illinois 60048 Christiansted, VI 00820
Ph. (847) 244-0222 (Illinois)/340-713-0330 (Virgin Islands) Fax (847) 244-7122 (Illinois)/ (340)-713-0335 (Virgin Islands)

Outside Medical Records Release Authorization

(Requesting your records from another provider)

I, ____ hereby authorize________________________________
Patient or legally authorized person physician/group

____
address phone/fax

to release the following information on:

Patient name: _____________________________________ Birth date: ______________________

Patient address: ____

Phone number: ______________________________

Please check all information to be released:

□ Entire record set
□ Registration record
□ Laboratory reports
□ Imaging reports (ultrasound/mammogram)
□ Other ____
□ Problem list
□ Medication list
□ Physician notes

Dates of treatment: ____

Information shall be released (sent) to: **Women's Healthcare Group of Illinois and/or The Women's Wellness Group**
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- *I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status.* □ ***Include these records*** □ ***Do not include these records***
- *I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.*

I authorize the following individuals to pick up my records:____
(must bring picture ID)

Authorized signature: ____ Date: ____________________

Relationship to patient: □ Patient □ Legal guardian □ Parent □ Healthcare power of attorney
(Submit signed copy)

Staff Initials ____________