The Wright Center for Women's Health
Phone: (630)687-9595 Fax: (630)839-5805

Authorization for Release of Medical Record Information

Patient Name: _____ Date of Birth:_____
Address:_____
Daytime Phone:_____ Evening Phone:_____
Release From:
Facility Name:_____
Facility Address:_____
Facility Phone Number:_____
Release To:
The Wright Center for Women's Health Mail Records_____
1763 Freedom Dr. Naperville, IL 60533 Fax Records_____
The information to be released is: (Please be specific)
_____:Progress/Office Notes _____:Operative Notes/Hospital Reports
_____:Laboratory/Pathology Reports _____:Mental Health Treatment Records
_____:X-Ray/Radiology Reports _____:Alcoholism Treatment Records
_____:Drug Abuse Treatment Records _____:HIV/AIDS Records
_____:Other: _____

From the time period:_____ to _____ (dates Month/Year)

Purpose for the information requested:
Continued Care:_____ Transfer of Care:_____ Personal:_____

I understand I may revoke this authorization at any time by written, dated and signed communication. This consent will remain in effect no more than ninety days from the date I signed the consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records **will not** be disclosed. Whether I sign or refused to sign, my treatment will not be affected.

Patient/Legal Guardian:_____ Date:_____

Printed Name:_____ Relationship:_____