Heartland Women's Healthcare

1-877-ILOBGYN (456-2496)
Fax: 618-997-5285
www.ILOBGYN.com
Mailing address: 3408 Office Park Drive, Marion, IL 62959

Release of Information Authorization

Type of Authorization:

☐ Release of protected health information From Heartland Women's Healthcare

☐ Release of protected health information To Heartland Women's Healthcare *Attention:* _____

The information to be released is:

_____ History
_____ Diagnosis
_____ Treatment
_____ Immunizations
_____ AIDS/HIV/STD
_____ Lab/Pathology Records
_____ Radiology/Ultrasound
_____ Psychological/Psychiatric Assessments
_____ Medications/Allergies
_____ Hospital/Operative Notes

Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth: _____ Maiden Name, if applicable _____

Provider: _____ Location: _____

☐ Send Record to OR ☐ Release Records From

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

I understand I may refuse to agree with and/or sign this release, but in doing so: I will not have access to my records.
Expirations or termination of authorization - This authorization will expire upon completion of this transaction. I have the right to terminate this authorization at any time. I understand this request will be honored except to the extent of any action already taken on this authorization prior to revocation.
Right to revoke or terminate - As stated in the Heartland Women's Healthcare Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can *be* done in person or by mailing a request to: Heartland Women's Healthcare Attn: Privacy Manager 3408 Office Park Drive, Marion, IL 62959.
Re-Disclosure - Heartland Women's Healthcare does not have control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Heartland Women's Healthcare.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

This Release of Information expires 90 days from the date of signature.