The Hope Clinic for Women Ltd.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ **Date of birth**_____

I hereby authorize:
FACILITY/PHYSICIAN _____

Address_____

Phone/Fax Number_____

□ The Hope Clinic for Women, Ltd; 1602 21st Street; Granite City, IL 62040; 618-451-5722; 618-451-9092 (fax)

TO RELEASE TO FACILITY/PHYSICIAN_____

Address_____

Phone/Fax Number_____

□ The Hope Clinic for Women, Ltd; 1602 21st Street; Granite City, IL 62040; 618-451-5722; 618-451-9092 (fax)

The following health information:

□ Complete medical record
□ History & Physical
□ Operative/Postoperative Notes
□ Pathology Report
□ other_____
□ Lab and/or test results
□ Radiology results (i.e. ultrasound or x-ray)
□ Progress Notes
□ Discharge Summary

*From the date(s) of treatment:*_____

For the purpose of:

□ continuity of care with a physician/organization
□ other _____
□ legal
□ personal use

This Authorization is voluntary and you may refuse to sign it. You may revoke this Authorization at any time. The revocation must be in writing with your signature and will take effect when The Hope Clinic for Women, Ltd. receives it. You have the right to inspect and/or receive a copy of the health information listed above and receive a copy of this Authorization form. The health information disclosed through this Authorization may no longer be protected by federal health information privacy laws. This Authorization will expire automatically 120 days from the date of signature.

Print Name_____ Signature_____

Date_____