GYNECOLOGIC CANCER INSTITUTE
of CHICAGO

AUTHORIZATION TO RELEASE INFORMATION

Name (Last, First):_____ Birthdate: _____ Today's Date: _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution_____ Fax_____

Address_____

City_____State_____Zip_____

TO: Person/Institution_____ Fax_____

Address_____

City_____State_____Zip_____

Disclosure will include: (*check all that apply*)

_____ Entire Record
_____ The medical records concerning the time period of _____.
_____ Operative/Procedure Notes
_____ Pap Smear Reports
_____ Biopsy Reports
_____ Laboratory Reports
_____ Progress Notes
_____ Pathology Reports
_____ CDs of imaging studies (CT, PET, MRI)
_____ Imaging study reports (CT, PET, MRI, mammograms, x-rays, etc.)
_____ History and Physical
_____ Face (demographic) Sheet

- I understand that I have the right to withdraw this authorization at any time.
- I understand that I do not have to sign this authorization to get treatment
- I understand that the medical records to be released may contain information related to HIV status, AIDS, alcohol or drug use, or mental health services and I hereby authorize release of this information. A written request may be submitted if you do not wish to have records containing this information be released to another physician or entity.
- I understand this authorization for release of information is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon.
- REDISCLOSURE**:** Notice is hereby given to the patient or legal representative signing this Authorization that Gynecologic Cancer Institute of Chicago, LLC cannot guarantee that the Recipient receiving the requested health information will not disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Patient's Signature_____ **Date** _____