ILLINOIS INSTITUTE OF GYNECOLOGY
&
ADVANCED PELVIC SURGERY

Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: ______________________ **Date of Birth:** ______________
Address: ______________________ **Telephone:** ______________

I HEREBY AUTHORIZE THE USE AND DISCLOSURE BY ILLINOIS INSTITUTE OF GYNECOLOGY AND ADVANCED PELVIC SURGERY OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ABOUT ME THAT IS DESCRIBED BELOW FOR THE SPECIFIC PURPOSE LISTED BELOW.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

□ entire medical record □office notes □ lab results □pathology reports □ record of HIV and communicable disease testing

Only send the following: ______________________ **Exclude**: ______________________

Date of Service from ______________________ **to** ______________________
Purpose of disclosure (please record the purpose of the disclosure)

____
(further care, request of the individual, personal use, attorney inquiry, etc.)

Persons or organization
disclosing the information:

______________________ Address: ______________________

PH: ______________________ Fax: ______________________

Persons or organization requesting/receiving
the information:

ILLINOIS INSTITUTE OF GYNECOLOGY AND ADVANCED PELVIC SURGERY
1351 WEST BELMONT AVE, CHICAGO, IL 60657
PH: 312-785-8881 **Fax: 312-956-2733**

I AUTHORIZE THE ABOVE USE AND DISCLOSURE:

Patient or Legally Authorized Representative

Signature: ______________________ Date: ______________

If signed by Legal Representative, Relationship to patient: ______________________

Signature of witness (when appropriate): ______________________ Date: ______________

You have the right to receive a copy of signed authorizations upon request.