ILLINOIS INSTITUTE OF GYNECOLOGY
&
ADVANCED PELVIC SURGERY

Authorization to Use or Disclose Health Information

Patient Name_____ Date of Birth_____

I authorize the use of disclosure of the above named individual's health information as described below. *Illinois Institute of Gynecology and Advanced Pelvic Surgery* is authorized to make the disclosure.

The type of information to be used or disclosed is as follows. **Please check all that apply**:

☐ Problem list
☐ Medication list
☐ List of allergies
☐ Most recent history
☐ Most recent discharge summary
☐ Lab results (dates or types)_____
☐ X-ray and imaging reports (dates or types)_____
☐ Consultation reports from_____
☐ Entire record
☐ Other_____

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name_____ Phone #_____

Address_____

I understand I have the right to revoke this authorization at any time. I understand that I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on:_____

Signature:_____ Date:_____
Patient or Legal Representative

If signed by legal representative, relationship to patient:_____

Signature of Witness:_____ Date:_____