**Effingham Obstetrics & Gynecology Associates, LLC**

912 N. Henrietta/PO Box 784
Effingham IL 62401
217-342-3337

## Authorization for Release of Confidential Health Information

Patient name:_____ Telephone:_____
Address:_____ Date of birth:_____
City/State/Zip:_____

| **OBTAIN FROM:** | **DISCLOSE TO:** |
|---|---|
| _____ (Physician/Institution) | _____ (Physician/Institution/Patient) |
| _____ (Address) | _____ (Address) |
| _____ (City, State, Zip) | _____ (City, State, Zip) |
| _____ (Phone) _____ (Fax) | _____ (Phone) _____ (Fax) |
| **For the purpose of:**<br>☐ Continuing Medical Care<br>☐ Insurance<br>☐ School<br>☐ Military<br>☐ Legal Purposes<br>☐ Social Security/Disability<br>☐ Patient's Request<br>☐ Other (specify)_____ | **Date (s) of Treatment:**<br>☐ Specific Dates: _____thru _____<br>☐ All Dates<br>**This expiration expires (date):_____**<br>**If date not specified, this release will expire 1 year after the date of the signature.** |

If released to another provider, do you wish to cancel all future appointments? **YES** **NO**

**Please check all records which you authorize to be released to the receiving party:**

| | |
|---|---|
| ☐ History & Physical | ☐ Pathology Reports |
| ☐ Office Visit Notes | ☐ Prenatal Records |
| ☐ Nurses Notes | ☐ Other:_____ |
| ☐ Lab Reports | ☐ Entire Medical Record |

By signing below:
I am releasing the following information that may include information related to Sexually Transmitted Infection, Acquired Immunodeficiency Syndrome, or Human Immunodeficiency Virus. It may also include information about behavioral mental health services and treatment for alcohol/drug/substance/ abuse. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office. **I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Effingham Obstetrics & Gynecology Associates, LLC, to use or disclose my health information in the manner described above.**

**Printed name of patient, legal guardian, or authorized agent: _____**
**Signature of patient or legal guardian, or authorized agent:_____**
**Date:_____** **Relationship to patient:_____**
**Witness Signature:_____** **Date:_____**