



Release of Information Authorization

To submit form, fax to 618-997-7180 or email to mr@usaobgyn.com.

Type of Authorization: Release of protected health information **From** New Horizons/Heartland Women's Healthcare.
 Release of protected health information **To** New Horizons/Heartland Women's Healthcare.

Type of Request: Personal _____ Transfer of Care _____ Continuation of Care _____

The information to be released is: History _____ Lab/Pathology _____ Diagnosis _____
Radiology/Ultrasound _____ Treatment _____ Psychological/Psychiatric Assessment _____
Immunizations _____ Medications/Allergies _____ AIDS/HIV/STD _____ Hospital/Operative Notes _____

Treatment Date To: _____ From: _____

Patient Name: _____ Maiden Name, if applicable _____

Date of Birth: _____ PH# _____

Provider: _____ Location: _____

Send Record to OR Release Records From

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

I understand I may refuse to agree with and/or sign this release, but in doing so: I will not have access to my records. Expirations or termination of authorization - This authorization will expire upon completion of this transaction. I have the right to terminate this authorization at any time. I understand this request will be honored except to the extent of any action already taken on this authorization prior to revocation.

Right to revoke or terminate - As stated in the Heartland Women's Healthcare Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to our Medical Records department. This can be done in person or by mailing a request to: Heartland Women's Healthcare Attn: Medical Records 3230 Veterans Memorial Drive, Mount Vernon, IL 62864.

Re-Disclosure - Heartland Women's Healthcare does not have control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Heartland Women's Healthcare. This release of information expires 90 days from the date of signature.

Patient Signature _____ Date _____

Witness Signature _____ Date _____