Heartland Women's Healthcare OF ADVANTIA

Release of Information Authorization

To submit form, fax to 833-431-2272 (IL patients) or 833-431-2275 (MO patients)
or email to mr@usaobgyn.com.

Type of Authorization: ☐ Release of protected health information **From** Heartland Women's Healthcare.
☐ Release of protected health information **To** 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 _____