

**Barrington Health Care for Women**  
**27401 W. Highway 22 #111**  
**Barrington, IL 60010**  
**847 382-2320**  
**Fax 847 382-0837**

I, \_\_\_\_\_ (print name)  
\_\_\_\_\_ (date of birth) \_\_\_\_\_ (phone)  
\_\_\_\_\_ (address)  
\_\_\_\_\_ (city, state, zip code)

Hereby authorize **Barrington Health Care for Women** to release to:

\_\_\_\_\_ (name of health care facility, or self)  
\_\_\_\_\_ (address)  
\_\_\_\_\_ (city, state, zip code)

\_\_\_\_\_ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must be specifically checked:

- \_\_\_\_\_ Mental health treatment records
- \_\_\_\_\_ Alcoholism treatment records
- \_\_\_\_\_ Drug abuse treatment records
- \_\_\_\_\_ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- \_\_\_\_\_ Laboratory Reports
- \_\_\_\_\_ X-ray Reports
- \_\_\_\_\_ Operative Notes
- \_\_\_\_\_ Other \_\_\_\_\_

The above information for the following period of time shall be released:

From \_\_\_\_\_ to \_\_\_\_\_ (dates of service)

The purpose of the authorization is \_\_\_\_\_  
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 provisions 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 disclose my health information. Written revocation must be sent to the physicians office.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FEE FOR COPYING RECORDS:**

Processing Fee: 24.44  
.92 per page for 1<sup>st</sup> 25 pages  
.61 per page for 26-50 pages  
.31 per page over 50 pages  
PLUS POSTAGE

ILLINOIS STATE LAW STATES THAT A PHYSICIAN HAS 30 DAYS AFTER RECEIPT OF THIS AUTHORIZATION TO SEND A COPY OF THE RECORD. A PHYSICIAN MAY CHARGE A REASONABLE FEE FOR COST OF TRANSFERRING RECORDS. WHILE INFORMATION IN A MEDICAL RECORD IS MAINTAINED FOR THE PATIENT'S BENEFIT, THE RECORD ITSELF IS THE PROPERTY OF THE PHYSICIAN. THE TREATING PHYSICIAN OWNS THE MEDICAL RECORD.