FOR OFFICE USE ONLY
Records Released
Date: ______________
Charges: $__________
Paid: Cash / Check / Credit
Records: Pickup / Fax / Mail
Initials: _________

BARRY SLOTKY, M.D., S.C.
Obstetrics & Gynecology
107 N. Regency Dr.
Bloomington, IL 61701

Authorization Form for Release of Confidential Health Information

I, ________________________________ hereby authorize
(Name of Patient or Authorized Agent)

Barry Slotky, M.D., S.C.
Obstetrics & Gynecology
107 N. Regency Dr.
Bloomington, IL 61701
Phone: 309.663.6338
Fax: 309.661.5644
www.drsltoky.com

to release to:

____
(Name of Physician / Practice)
____
(Street Address)
____
(City, State, Zip)
______________ / ______________
(Phone Number) *(Fax Number)*

the following information contained in the patient record of: ______________________
(Patient's Name)

born ____________, residing at ______________________________ / ______________
(Birthdate) *(Street Address, City, State, Zip)* *(Phone Number)*

- ☐ The entire medical record, including mental health treatment, alcoholism treatment, drug abuse treatment and HIV / acquired immune deficiency syndrome (AIDS) records.
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Operative Reports
- ☐ Other: ____

The above information from the following period of time shall be released:
From: ____________ to ____________.
(Date) *(Date)*

The purpose(s) of this authorization is (are): ________________________________

____.

- I understand that I have the right to inspect and copy information I have authorized to be disclosed by this authorization. In the event I refuse to authorize 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 where the provision of 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 re-disclosure 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 physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate 180 days from date release signed.

Signed: ________________________________ Date: ______________

If you are not the patient, please specify your relationship to the patient: ______________