Women Ob-Gyn Associates, P.C.

Obstetrics & Gynecology

Naheed R. Akhter, M.D., FACOG
Amy K. Gaunt, M.D., FACOG

Telephone (630) 719-9229
Fax (630) 719-9452

Patient Name _____ Date of Birth _____
Address: _____
Phone Number: _____

I hereby authorize that the protected health information regarding the above named person be forwarded as follows:

FROM	TO
☐ **Dr. Akhter** ☐ **Dr. Gaunt** **Women Ob-Gyn Associates, P.C.** **4121 Fairview Avenue, Suite 201** **Downers Grove, IL 60515** **T: 630-719-9229 F: 630-719-9452**	_____ _____ _____

____ Entire medical record
____ X-ray ____Ultrasound ____ Mammogram reports (check one requested)
____ Operative reports: Specific Procedure: _____
____ Other: _____

To be included, the following items must specifically be checked:
____ Mental Health Treatment Records ____ Alcoholism Treatment Records
____ Drug Abuse Treatment Records ____ HIV/acquired Immune Deficiency Syndrome (AIDS) Records
The above information for the following period of time shall be released:
From:_____(Date) to_____(Date)

The purpose of the authorization is:
____ Moving ____ Insurance Conflict ____ 2nd Opinion ____ Transfer of Care ____ Primary Physician

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 re-disclosure by the recipient and may no longer be protected by law.
I understand that I may revoke this authorization at any time be 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 if Confidential Health Information will terminate on _____.

I understand that there will be a fee charge to me to cover the cost of copying and sending my records.

_____ _____
Signature of Patient **Date**

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