## NYE PARTNERS IN WOMEN'S HEALTH

625 N. Michigan Avenue Suite 210 Chicago, Illinois 60611

Telephone: 312-670-2530 Fax: 312-670-2630

## **AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

Patient's Name (PRINT)		Office Medical Record #		
Patient's Signature	Date of Birth		DATE	
Social Security Number		•	If not patient, signature and relationship of person giving authorization	
[ ] I authorize NYE Partn	ers in Women's Health t	o send a copy	of my medical records to:	
[ ] I authorize NYE Partn	ers in Women's Health t	o request my n	nedical records from:	
Name of Physician		Health Care Facility		
Street Address				
			()	
City	State	Zip	Phone Number	
THIS AUTHORIZATION APPI	LIES TO THE FOLLOW	ING INFORMA	TION:	
			ment, alcoholism treatment,	
	atment, & HIV - Acquire ne Deficience Syndrome		ciency Syndrome (AIDS) records Is	
[ ] Laboratory Reports	(specify)			
[ ] Radiology Reports (	specify)			
[ ] Operative Reports (	specify)			
[ ] Other				
THE PURPOSE OF THIS REL	EASE IS FOR: [ ] M	oved [	] Changing insurance	
[ ] Second opinion [ ] Prim	ary Care Physician upd	ate [	] Changing physicians	
EXPIRATION NOTICE: I understand will expire 90 days from the date sign		at any time prior t	o the release of information. This authorize	

RECORDS FROM OTHER HEALTH FACILITIES/REDISCLOSURE: It is the policy of NYE Partners in Women's Health to release only medical information documented or dictated by NYE Partners in Women's Health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need. Federal regulations prohibit us from redisclosing information without the specific written consent of the person(s) to whom it belongs.