CHICAGO WOMEN'S HEALTH CENTER

COMPASSIONATE - COLLABORATIVE - COMPREHENSIVE

Medical Records Request Form

This form allows us to request your records from another healthcare provider

Date:_____

Client Name:_____ ***Date of Birth:***_____

Address:_____

Phone:_____

I authorize the Chicago Women's Health Center to request the following:

___Specific Lab Reports:_____

___All Lab Reports

___Specific Visit Notes:_____

___Complete Medical Record

___Other:_____

Date(s) of records to be requested:_____ through_____

Records Requested From:

Name:_____

Address:_____

Phone and Fax:_____

(It is important that you give as much contact information as you can, especially the provider's name and phone.)

- *I understand that this authorization shall be valid from _____(date) through_____(date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.*
- *I understand that the information requested may not be re-released to any other person or organization without my written consent.*

Signature:_____ ***Date:***_____

Please fax records to 773-935-7145, or
Mail to CWHC, 1025 W. Sunnyside Ave, Ste 201, Chicago, IL 60640
Questions? Call 773-935-6126.