Galvan OBGYN & Associates
Dr. Jeffrey J. Galvan
1300 Franklin Ave., Suite 330
Normal, IL 61761
309-454-7400

Authorization for Release of Information

PLEASE PRINT OR TYPE ALL INFORMATION

Account #________
Date request received________
Who received request________

(Physician/Clinic Name)
Authorization is given to: ____
(Name) (Address) (City, State, Zip)

To release to: ____
(Name and full address of entity records are to be sent to)

Information on patient (full name):________________ Date of Birth: ________

Dates of Service – From: ________ Through: ________

For the purpose of: ☐ Continuation of Care ☐ Transferring care to another physician ☐ Other: ________
(Explain other purpose)

Do you (the patient or legal representative) authorize release of psychiatric information	Yes	No
Do you (the patient or legal representative) authorize release of chemical dependency information?	Yes	No
Do you (the patient or legal representative) authorize release of HIV/AIDS information?	Yes	No
Do you (the patient or legal representative) authorize release of genetic information:	Yes	No

The following information is requested:

☐ Problems ☐ Medications ☐ Immunizations ☐ Allergies ☐ Chart Notes
☐ Procedures ☐ Laboratory ☐ X-rays ☐ EKG, EEG, EMG, other tests
☐ Other, please specify: ________________________

Name of Requestor: ________________ **Relationship to patient:** ________

Requestor's Address (Street, City, State, Zip): ________________________

Requestor's day time phone number: ____________ **Alternate phone number:** ________

Permission is granted to fax the records: **circle one** **YES NO** **Fax number to fax records to:** 309) 454-7471

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____
Signature of Requestor (Patient or Legal Representative) Date of Request

____
Name of Witness Signature of Witness Date of Request

The patient must sign this authorization. If the patient is under 18, or is physically unable to sign, the authorization is to be signed by the patient's legal guardian or representative. In cases of mental incompetence, the legal guardian must sign.

FOR OFFICE USE ONLY:

Signature verified by: ☐ Witnessed ☐ Comparison
I.D. verified by (Galvan OBGYN employee name): ________________

Method of I.D. verification: ☐ State or Federal Photo ID ☐ Driver's License #
Records to be released via: ☐ In Person ☐ Mailed ☐ Faxed (with patient's permission)

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.