ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH AND FAMILY SERVICES
BREAST AND CERVICAL CANCER PROGRAM

AUTHORIZATION TO OBTAIN INFORMATION

I hereby give consent to release the following information:

- ☐ Clinic Report
- ☐ Medical Reports
- ☐ Laboratory Report
- ☐ Other _____

Regarding:
Client's Name: _____

Client's Address: _____

Date of Birth: _____/_____/_____

To: Agency Name & Address, ATTN: Illinois Breast & Cervical Cancer Program

_____

_____

_____

Phone: _____

I agree to release said provider, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice. Unless I revoke sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be valid as the original, even though such copy does not contain the original writing of my signature.

_____ _____
Signature Date

_____ _____
Witness Date