Judith Cothran, MD, FACOG
4905 Old Orchard Center, Ste. 200
Skokie, IL 60077
847-673-3130

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Requested by: _____ Date Requested: _____

Patient's Name: ❑same as above or - _____ Date of Birth: _____

Previous Name: _____ Soc. Sec.: _____

Patient's Address: _____

_____

_____

Mail to: **Judith A. Cothran, MD, FACOG**
Women's Health of Chicago
4905 Old Orchard Center
Skokie, IL 60077

FAX TO: 847-673-3183

Questions? Call: 847-673-3130

This request and authorization applies to :

❑ **Healthcare information relating to the following treatments, conditions, or dates:**

_____

_____

❑ **ALL healthcare information**

❑ **Other:** _____

_____

Definition: Sexually Transmitted Diseases (STDs) include herpes, human papilloma virus, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ **YES** ❑ **NO**	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. (see above definition)

❑ **YES** ❑ **NO**	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

This authorization expires 90 days after the date signed.