

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF WOMEN'S HEALTH  
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