



Authorization to Release Protected Health Information



ROI

Patient Name: _____ Date of Birth: _____

Other Names: _____ Last 4 digits of SSN: _____ MRN: _____

I authorize: Carle -Health Information Management
3310 Fields South Drive
Champaign, IL 61822

To Release to: _____
OR
(Name of Health Care Facility, Individual, or Agency, etc.)

To Request from: _____
(Address)

(City, State, Zip)

(Phone)

(Fax)

Method of Release: Mail Pick up at HIM Department (217) 383-3381 MyCarle Account (Available for 30 days)

SPECIFIC RECORDS TO BE RELEASED:

HOSPITALIZATION	Dates: _____ to _____	CLINIC/OTHER	Dates: _____ to _____
<input type="checkbox"/> Inpatient Hospitalization	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Office Visits (Specify Provider) _____
<input type="checkbox"/> Abstract	<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Reports <input type="checkbox"/> Images	_____
<input type="checkbox"/> Complete Stay	<input type="checkbox"/> Pathology	<input type="checkbox"/> Immunization Record	_____
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Report(s) <input type="checkbox"/> Slides	<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Emergency Department
<input type="checkbox"/> Consult(s)	<input type="checkbox"/> Radiology (X-ray)	<input type="checkbox"/> Pathology	Visit(s)
<input type="checkbox"/> Progress Note(s)	<input type="checkbox"/> Reports <input type="checkbox"/> Images	<input type="checkbox"/> Report(s) <input type="checkbox"/> Slides	<input type="checkbox"/> Home Care/Hospice
<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> Therapy Services	<input type="checkbox"/> Radiology (X-ray)	<input type="checkbox"/> One-Day Surgery
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other _____	<input type="checkbox"/> Reports <input type="checkbox"/> Images	<input type="checkbox"/> Therapy Services
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Billing Records		<input type="checkbox"/> Other _____
<input type="checkbox"/> Reports <input type="checkbox"/> Images			<input type="checkbox"/> Billing Records

- The purpose of this disclosure of information is _____
(i.e., continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol and/or substance abuse, and genetic testing results. A separate special authorization must be completed to release mental health records.
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in one year.
- I understand that I am entitled to a copy of this authorization.
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

If the patient is 18 years of age or older, the patient must sign and date the form.

If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: Parent Legal Guardian

Signature: _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____ Phone#: _____

Mailing Address of Patient: _____ City: _____ State: _____ Zip: _____

STAFF USE ONLY - Released by: Staff Initials _____ Type of ID Verified _____ Date: _____