



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 Send to: _____
(Name of Health Care Facility, Physician, Individual, or Agency, etc.)

OR
To Request from: _____
(Address)

(City, State, Zip) (Phone) (Fax)

Method of Release: Mail Pick up at HIM Department (217) 902-6500 MyCarle Account (Available for 30 days)

SPECIFIC RECORDS TO BE RELEASED:

Table with 4 columns: HOSPITALIZATION, CLINIC/OTHER, and two Date columns. Rows include checkboxes for Inpatient Hospitalization, Cardiology, Office Visits, etc.

- The purpose of this disclosure of information is...
I understand that my medical record may include information relating to sexually transmitted disease...
I have the right to inspect and obtain a copy of the records that are to be disclosed...
I understand that I am not required to sign this authorization in order to seek medical treatment...
I understand that I may revoke this authorization at any time...
This authorization will expire on the following date or event...
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: