CarleHealth

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

__ City:______ State:_____ Zip:______

____ Date:____

ROI

Other Names: Last 4 digits of SSN: MRN: I authorize: Carle Health Information Management S401N Knoxville Ave. Ste 418, Peoria, IL 61614 P: (309)691-1047 F: (309) 691-1025 Prior Send to: Prior Request from: (Adress) City, State. Zip) (Phone) (Fax) Method of Release: Mail MyCarle Account (Available for 30 days) SPECIFIC RECORDS TO BE RELEASED: If no dates are indicated, only records created prior to or on the date of signature will be released HOSPTALIZATION Dates: to CLINIC/OTHER Dates: to Complete Stay Pathology Office Visits (Specify Prc District District Pathology Visit(s) Disprate Note(s) Reports Images Diffice Visits (Specify Prc Pathology Visit(s) Energency Department Discharge Summary Other Pathology Visit(s) Reports Inages One-Day Surgery I claridology Other Billing Records Reports Images Other Discharge Summary Other I cardiology I Billing Records Reports Inages Other Discharge Summary Other Discharge Surgery	Patient Name:				Date of Birth:	
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OR [Name of Health Care Facility, Physician, Individual, or Agency, etc.) To Request from: [Address] (Ciry, State, Zip) (Phone) (Fax) SPECIFIC RECORDS TO BE RELEASED: If no dates are indicated, only records created prior to or on the date of signature will be released Images Images Inpatient Hospitalization Immunization Record Cardiology Office Visits (Specify Pre Abstract Baboratory Report(s) Cardiology Immunization Record Immunization Record Complete Stay Pathology (X-ray) Integes Pathology Visits) Opgress Note(s) Reports mages Reports Mages Reports Mages Pathology Visits) Opgress Note(s) Reports Images Reports Images Other Billing Records Cardiology Billing Records Immunization relating to sexually transmitted disease, acquired immunodeficiency visy, syndrome (ADS), human immunodeficiency visy, emendation relating to sexually transmitted disease, acquired immunodeficiency visy, syndrome (ADS), human immunodeficiency visy, emendation relating to sexually transmitted disease, acquired immunodeficiency visy, solidator substance abuse, and genetic testing results. / separats special authorization must be completed to release mental health records. I understand that my medical record may include information relating to sexually		5401 N Knoxville	e Ave. Ste 418, F	ement Peoria, IL 61614		
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Printed Name of Person Signing (if not patient):Phone#:Phone#:	this form. If the patient is 18 year If the patient is 18 year Please indicate your leg Legal Guard If the patient is 17 year exception exists under s Signature:	rs of age or older, rs of age or older a al authority and ind ian or Conservator rs of age or young state or federal law	the patient must and is incapable clude documenta	t sign and date the form. e of signing, a legally authorized ation of your relationship: Agent (Health Care Power of At parent or legal guardian must s your relationship: Date Sign	d substitute may sign and ttorney) sign and date the form, u arent □ Legal Gu red:	d date the form. nless an ardian

Mailing Address of Patient:_

STAFF USE ONLY - Released by: Staff Initials______ Type of ID Verified_____