Place Label Here

Carle
Richland Memorial Hospital

MENTAL HEALTH RECORDS AUTHORIZATION

P: (618) 395-7340 X 4091
F: (618) 393-4215

1. PATIENT INFORMATION

Patient Name:_____ Birthdate:_____
Street Address:_____ City, State, Zip:_____
Maiden/Other Name(s):_____ Phone#: (home)_____ (work)_____

I authorize the use/disclosure of my mental health records and/or information as follows:

2. PARTY WHO HAS MY MENTAL HEALTH RECORDS (WHO IS SENDING MY RECORDS)

☐ Carle and any Carle entity
☐ Other:_____ Phone #: (_____)_____
Street Address:_____ City, State, Zip:_____

3. PARTY OR PARTIES WHO I WANT TO RECEIVE MY MENTAL HEALTH RECORDS (WHO WILL GET MY INFORMATION)

☐ Carle and any Carle entity
☐ Other:_____ Phone #: (_____)_____
Street Address:_____ City, State, Zip:_____

4. PURPOSE OF USE/DISCLOSURE OF MY MENTAL HEALTH RECORDS AND/OR INFORMATION

☐ Medical follow-up ☐ Employment reasons ☐ Underwriting (insurance)
☐ Lawsuit ☐ Patient request (I do not wish to be more specific.)

5. THE DATES OF RECORDS AND/OR INFORMATION TO BE USED OR DISCLOSED:

☐ Records or information from:_____ to_____
[Beginning Date] [End Date]

6. DESCRIPTION OF MY MENTAL HEALTH RECORDS AND/OR INFORMATION TO BE USED AND DISCLOSED

☐ Office Visit-Psychology/Psychiatry
☐ Hospital Progress Notes-Psychiatry
☐ Testing Data-Psychiatry
☐ Labs
☐ X-Ray
☐ Billing Records
☐ Other:_____

7. EXPIRATION

This authorization will expire one (1) year from the date I sign it. If I want it to expire on a different date, then that date is:

_____

8. CANCELING THIS AUTHORIZATION:

I may cancel this authorization before it expires by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to Carle Health Information Management at the address shown on the back of this page. The cancellation will take effect when Carle receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Carle received my letter.

Please turn to the back of this page.

9. RE-DISCLOSURE OF MY HEALTH RECORDS AND/OR INFORMATION:

I understand that the person who receives my mental health information records may NOT disclose it to someone else without my permission, unless permitted by law.

10. EFFECT OF NOT SIGNING THIS AUTHORIZATION:

I am not required to sign this authorization in order to receive most health care services at Carle. However, I understand that if the ONLY reason I am seeing a Carle provider is to create health information for someone else's use (such as my employer), Carle may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, then I must sign this authorization in order for Carle to perform the pre-employment test.

11. FEES:

I may be charged a copying fee to complete this request. I may ask Carle for a fee estimate. If there is a fee, the bill may come from CIOX, the company that processes health information requests for Carle. For questions regarding potential fees please contact the correspondence department at the number below.

12. RIGHT TO INSPECT & COPY:

I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization.

13. MY AUTHORIZATION:

_____ _____

Signature of Patient 12 years old and over — Date Signed

_____ _____

Signature of Legal Representative or Guardian — Date Signed

_____ _____

Printed Name of Representative or Guardian — Relationship to Patient (Authority to Sign for Patient)

_____ _____

Signature of Witness to Patient's Signature — Date Signed

14. INSTRUCTIONS FOR RECORD COPY REQUESTS ONLY (CHECK ONE IF APPLICABLE):

☐ Mail record copies out to party or parties I named in #3 ☐ I will pick up records

15. RETURN THIS COMPLETED FORM TO:

Carle-Richland Memorial Hospital
ATTN: Medical Records
800 E. Locust Street
Olney, IL 62450
(618) 395-7340 x 4091

16. PROVIDER RELEASE NOTIFICATION: (OFFICE USE ONLY)

☐ _____ has been notified of this release _____(initials/date)
☐ _____ has been notified of this release _____(initials/date)
☐ HIM has notified all providers _____(initials/date)
☐ _____ has denied this release_____(initials/date)

Provide Copy of Signed Form to Patient