AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

ROI

Patient Name:_____ Date of Birth:_____

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

I authorize: The Carle Foundation* -Health Information Management
3310 Fields South Drive, Champaign, IL 61822
**Includes Carle Physician Group and Carle Hoopeston Regional Health Center*

☐ To Send to:
OR
☐ To Request from:

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

_____
(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: *If no dates are indicated, only records created prior to or on the date of signature will be released.*

HOSPITALIZATION Dates:_____ to _____		CLINIC/OTHER	Dates:_____ to _____
☐ Inpatient Hospitalization ☐ Abstract ☐ Complete Stay ☐ History and Physical ☐ Consult(s) ☐ Progress Note(s) ☐ Operative Report(s) ☐ Discharge Summary ☐ Cardiology ☐ Reports ☐ Images	☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images ☐ Therapy Services ☐ Other_____ ☐ Billing Records	☐ Cardiology ☐ Reports ☐ Images ☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images	☐ Office Visits (Specify Provider) _____ _____ ☐ Emergency Department Visit(s) ☐ Home Care/Hospice ☐ One-Day Surgery ☐ Therapy Services ☐ Other _____ ☐ 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 on the date of the signature below and records will only be released for services up to and including that date.
- 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:_____*