



# PATIENT HEALTH INFORMATION AUTHORIZATION

## INSTRUCTIONS

- Mail records out to party I named in #4
- Patient given copy by Carle staff \_\_\_\_\_(initials) - Mental Health requires Mental Health Authorization
- I will pick up records (Farber only)

## 1. PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ SS#: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Clinic#: \_\_\_\_\_  
 Maiden/Other Names: \_\_\_\_\_ Phone#: (home) \_\_\_\_\_ (work) \_\_\_\_\_

I authorize the use/disclosure of my health information as follows:

## 2. FEES

**I may be charged a copying fee for this request to disclose my health information. I may ask Carle for a fee estimate. If I receive a bill for processing this request, the bill may come from Healthport, the company that processes health information requests for Carle.**

## 3. PARTY WHO HAS MY HEALTH INFORMATION

- Carle and any Carle Entity
- Other Organization: \_\_\_\_\_  
 [NAME] [PHONE NUMBER]  
 [STREET ADDRESS]  
 [CITY] [STATE] [ZIP]

## 4. PARTY WHO I WANT TO RECEIVE OR USE MY HEALTH INFORMATION

- Carle and any Carle Entity
- Other Organization: \_\_\_\_\_  
 [NAME] [PHONE NUMBER]  
 [STREET ADDRESS]  
 [CITY] [STATE] [ZIP]

## 5. PURPOSE OF USE/DISCLOSURE OF MY HEALTH INFORMATION

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

## 6. DESCRIPTION OF MY HEALTH INFORMATION (FROM ENTITY INDICATED IN #3 ABOVE) TO BE USED AND DISCLOSED (if not specifically limited or restricted the types of information to be disclosed may include records and results of Communicable disease/HIV and test results)

- Dates of Service: \_\_\_\_\_ to \_\_\_\_\_  
 [BEGINNING DATE] [END DATE]
- Inpatient Abstract
- Operative Reports
- Radiology Reports
- Films / Image CD
- Immunization Records
- Emergency Room
- Office Visit Notes
- Therapy Services (please circle): Speech, PT or OT
- Lab/Pathology Reports
- Billing Records
- Other: \_\_\_\_\_

**[Please turn to the back of this page]**

SPECIALLY PROTECTED RECORDS (CHECK AND INITIAL)

\_\_\_\_\_  Alcohol/drug abuse treatment records

Only records from: \_\_\_\_\_ to \_\_\_\_\_  
[BEGINNING DATE] [END DATE]

\_\_\_\_\_  Genetic test results

Only records from: \_\_\_\_\_ to \_\_\_\_\_  
[BEGINNING DATE] [END DATE]

**7. EXPIRATION**

This authorization will expire 90 days from the date I sign it. If I want it to expire on a different date, or after a certain event occurs, then it 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 at the bottom 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.

**9. RE-DISCLOSURE OF MY HEALTH INFORMATION**

I understand that the health information disclosed under this authorization may be redisclosed by the recipient without my permission and may no longer be protected by the laws and regulations applicable to the organization that sent the information. However, no person may re-disclose my alcohol and drug abuse records or HIV records without additional permission from me (unless the law allows it).

**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. MY AUTHORIZATION**

\_\_\_\_\_  
[SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE]

\_\_\_\_\_  
[DATE OF SIGNATURE]

\_\_\_\_\_  
[AUTHORITY TO SIGN IF NOT PATIENT/RELATIONSHIP TO PATIENT]

**12. RETURN THIS COMPLETED FORM TO:**

**CARLE HIM DEPARTMENT  
RELEASE OF INFORMATION  
2902 FARBER DRIVE  
CHAMPAIGN, IL 61822  
(217) 383-3381**