



**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 RECORDS AND/OR INFORMATION:**

I understand that the person who receives my mental health information 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 processing 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 a company that processes health information requests for Carle.

**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]

\_\_\_\_\_  
[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 HIM DEPARTMENT  
2902 FARBER DRIVE  
CHAMPAIGN, IL 61822**

**16. PROVIDER RELEASE NOTIFICATION:**

- Dr. \_\_\_\_\_ has been notified of this release \_\_\_\_\_ (initials/date)
- Dr. \_\_\_\_\_ has been notified of this release \_\_\_\_\_ (initials/date)
- HIM has notified all providers \_\_\_\_\_ (initials/date)
- Dr. \_\_\_\_\_ has denied this release \_\_\_\_\_ (initials/date)

**Provide Copy of Signed Form to Patient**