Carle Clinic
602 West University Avenue
Urbana, IL 61801-2594

Carle
Carle Foundation Physician Services
Carle Foundation Hospital
611 W. Park St., Urbana, IL 61801-2595

PATIENT HEALTH INFORMATION AUTHORIZATION

174-1008

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. Party who has my Health information

❑ Carle Clinic Association ❑ Carle Foundation Hospital ❑ Champaign SurgiCenter

❑ Carle Foundation Physician Services ❑ Other: ______________________________

Other Party Address: ______________________________

City, State, Zip: ______________________________

3. Party Who I want to Receive or Use my Health Information

❑ Carle Clinic Association ❑ Carle Foundation Hospital ❑ Champaign SurgiCenter
❑ Carle Foundation Physician Services

❑ Other: ______________________________
[Name]

____
[Street Address]

____
[City] [State] [Zip]

4. 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:______________________________

5. 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 a company that processes health information requests for Carle.

6. Description of My Health Information to be used and Disclosed

❑ Carle Clinic Association ❑ Carle Foundation Hospital
❑ Carle Foundation Physician Services ❑ Carle SurgiCenter

❑ Only records from: ________________ to ________________
[Beginning Date] [End Date]

❑ Inpatient Physician Progress Notes ❑ Office Visit Notes
❑ Operative Reports ❑ Flow Records
❑ Radiology Reports ❑ Therapy Services (specify therapy):__________
❑ Films ❑ Lab/Pathology Reports
❑ Immunization Records ❑ Billing Records
❑ Independent medical examination ❑ Complete Chart for above checked organization

❑ Other:______________________________

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[Please turn to the back of this page]

C. Specially Protected records*

- ❑ Alcohol/drug abuse treatment records

  Only records from: ___________________ to _____________________
  [Beginning Date] [End Date]

- ❑ Communicable disease/HIV test results
  Only records from: ___________________ to _____________________
  [Beginning Date] [End Date]

- ❑ Genetic test results
  Only records from: ___________________ to _____________________
  [Beginning Date] [End Date]

**Note: Mental health records require use of separate Mental Health Records Authorization Form.*

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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:____

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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.

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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).

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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.

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11. My authorization

____ _____________________________
[Signature of Patient or legal representative] [Date of Signature]

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[Authority to Sign if Not Patient]

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12. Return this completed form to:

Carle HIM Department
600 North Coler Ave.
Urbana, IL 61801

13. Instructions

- ❑ Mail records out to party I named in #3
- ❑ I will pick up records
- ❑ Patient given copy by Carle staff

Provide Copy of Signed Form to Patient