Christie Clinic
101 West University Ave.
Champaign, IL 61820
Phone: (217) 366-9656
Fax: (217) 366-1294

Medical Record Release Authorization

CHRISTIE CLINIC

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ SSN: _____

_____ Telephone: _____

Information is to be released by:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

_____
(Fax Number)

Information is to be sent to:

_____
(Individual/Agency/Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

_____
(Fax Number)

I Request My Records be Provided: ☐ Paper (hard copy) ☐ Electronically via email* ☐ Electronically via CD*

Email Address: _____

***Electronic access via email will be through the Quest HIMS portal only.**

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Physician Office Notes	☐ Cardiology/EKG Report	☐ Radiology/X-ray/MRI Report
☐ Immunizations	☐ Lab/Path Report	☐ Other _____
☐ Operative/Procedure Report		

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ N**o**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____, or 90 days from date of signature, unless otherwise specified.

Re-release

I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. The cost of obtaining copies of your medical records for your own personal use will be $13 per request. If the request is for continuing care and provided directly to a physician, all fees associated with the release of information will be waived and provided free of charge. All Requests for Information will be fulfilled by Quest HIMS. Any correspondence, as well as payment should be directed to Quest HIMS at 618-355-9550. **By signing below, you authorize your provider, identified above, to release your protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign - if not patient: _____ Witness: _____