



**AUTHORIZATION FOR USE OR
DISCLOSURE OF HEALTH
INFORMATION**

101 West University Avenue
Champaign, IL 61820
(217) 366-9656
H.I.S. FAX (217) 366-1294

Patient Name _____ Mail Record _____ I Will Pick Up _____

Patient Address _____ MRN # _____

Date of Birth ____/____/____ Phone Number _____ Paper Copy _____ Electronic Copy _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me which is called "protected health information" under a federal health privacy law, as described below:

1. Persons/organization authorized to make the disclosure: (please include address)
FROM: _____
2. Persons/organization to whom the disclosure may be made: (please include address)
TO: _____
3. Specific description of the information to be used or disclosed (check all that apply and include dates of service, where applicable):
Laboratory results _____
X-ray reports _____ X-ray films _____
Mental health records (psychiatry or substance abuse) _____
Visit notes _____
Other _____
4. The protected health information will be used and/or disclosed for the following purposes:
 Changing Insurance Carrier Moving from the area Attorney request
 Claim processing Provider Preference Specialist Other
5. I understand that the protected health information in my record may include information relating to sexually transmitted diseases (STD), tuberculosis (TB), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, and genetic testing.
Initial here to agree: _____; or list information to be excluded: _____
6. Revocation/Expiration. This authorization can be revoked in writing at any time unless the Clinic has already acted upon your request. Submit your written request to the Health Information Department. Without expressed written revocation, this authorization expires one year after it is signed, or upon the following specific date, event or condition: _____
7. I understand that any costs incurred in producing this information will be my responsibility.

My authorization to disclose the above information is voluntary, and Christie Clinic will not condition the provision of treatment on this authorization. I understand if I refuse to sign this form that the requested information will not be released. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by the laws and regulations applicable to Christie Clinic. If I have questions about use and disclosure of my health information, I may contact the Health Information Services Department.

Signature of Patient (or Personal Representative) and Relationship to Patient

Date

Signature of Parent (if minor child) or Signature of Minor Age 12 yrs. To 17 yrs.

Date

Witness Signature

Witness Printed Name

IMPORTANT NOTICE: ANY INFORMATION PROTECTED BY FEDERAL REGULATIONS GOVERNING SUBSTANCE ABUSE TREATMENT (42 CFR, PART 2) OR THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT IS PROHIBITED FROM FURTHER DISCLOSURE UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.