CHRISTIE CLINIC
*Medicine for Your Life*

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

101 West University Avenue
Champaign, IL 61820
(217) 366-1285
FAX (217) 366-6129

Patient Name _____ Mail Record _____ I Will Pick Up _____ *

Date of Birth ____/____/_____ Phone Number _____ History #_____

** Please Note: We will make your CD once you arrive. Your wait should be no greater than 10 minutes.*

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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)

2. Persons/organization to whom the disclosure may be made:(please include address)

3. Specific description of the information to be used or disclosed (check all that apply and include dates of service, where applicable):
   - ❑ X-ray images_____
   - ❑ C.T. images _____
   - ❑ MRI images _____
   - ❑ Mammography images _____
   - ❑ Nuclear Medicine images _____
   - ❑ Ultrasound images _____

4. The protected health information will be used and/or disclosed for the following purposes:
   - ❑ Moving from the area ❑ Attorney request
   - ❑ Provider preference ❑ Other_____

5. 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 Radiology Department. Without expressed written revocation, this authorization expires one year after it is signed or upon the following specific date, event or condition: _____.

6. I understand that any costs incurred in producing this information will be my responsibility. _____ (initials)

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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

Date picked up _____ Initials _____ (please show identification when picking up images in person)

**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.**