

# Authorization to Release Protected Health Information



ROI

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Other Names: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_ MRN: \_\_\_\_\_

I authorize: Carle Health\* - Health Information Management  
1304 Franklin Ave., Normal IL, 61761 | P: (309) 268-5274  
\*Includes Carle West Physician Group, Carle BroMenn Medical Center, and Carle Eureka Hospital, Carle Cancer Institute Normal

To Send to: \_\_\_\_\_  
**OR**  
 To Request from: \_\_\_\_\_  
(Name of Health Care Facility, Physician, Individual, or Agency, etc.)  
(Address)  
(City, State, Zip) (Phone) (Fax)

Method of Release:  Mail  Pick up at HIM Department (309) 268-5274  MyCarle Account (Available for 30 days)

**SPECIFIC RECORDS TO BE RELEASED:** *If no dates are indicated, only records created prior to or on the date of signature will be released.*

HOSPITALIZATION	Dates: _____ to _____	CLINIC/OTHER	Dates: _____ to _____
<input type="checkbox"/> Inpatient Hospitalization <input type="checkbox"/> Abstract <input type="checkbox"/> Complete Stay <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult(s) <input type="checkbox"/> Progress Note(s) <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Cardiology <input type="checkbox"/> Reports <input type="checkbox"/> Images	<input type="checkbox"/> Immunization Record <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Pathology <input type="checkbox"/> Report(s) <input type="checkbox"/> Slides <input type="checkbox"/> Radiology (X-ray) <input type="checkbox"/> Reports <input type="checkbox"/> Images <input type="checkbox"/> Therapy Services <input type="checkbox"/> Other _____ <input type="checkbox"/> Billing Records	<input type="checkbox"/> Cardiology <input type="checkbox"/> Reports <input type="checkbox"/> Images <input type="checkbox"/> Immunization Record <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Pathology <input type="checkbox"/> Report(s) <input type="checkbox"/> Slides <input type="checkbox"/> Radiology (X-ray) <input type="checkbox"/> Reports <input type="checkbox"/> Images	<input type="checkbox"/> Office Visits (Specify Provider) _____ <input type="checkbox"/> Emergency Department Visit(s) <input type="checkbox"/> Home Care/Hospice <input type="checkbox"/> One-Day Surgery <input type="checkbox"/> Therapy Services <input type="checkbox"/> Other _____ <input type="checkbox"/> Billing Records

- The purpose of this disclosure of information is \_\_\_\_\_  
(i.e., continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol and/or substance abuse, and genetic testing results. A separate special authorization must be completed to release behavioral health records.
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following calendar date or event \_\_\_\_\_. If I do not specify an expiration date or event, this authorization will expire on the date of the signature below and records will only be released for services up to and including that date.
- I understand that I am entitled to a copy of this authorization.
- I understand there may be a charge to obtain a copy of these records.

**ATTENTION:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

If the patient is 18 years of age or older, the patient must sign and date the form.

If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:  Legal Guardian or Conservator  Health Care Agent (Health Care Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:  Parent  Legal Guardian

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Printed Name of Person Signing (if not patient): \_\_\_\_\_ Phone#: \_\_\_\_\_

Mailing Address of Patient: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**STAFF USE ONLY** - Released by: Staff Initials \_\_\_\_\_ Type of ID Verified \_\_\_\_\_ Date: \_\_\_\_\_

