Medical Record Release Authorization

For Clinic Staff use:
Completed Date:
Pages: By:
☐Faxed ☐ Given To Patient

Patient Name (First Middle Last)	Other names (ex: Maiden)	Date of Birth (MM/DD/YY)	Social Security (Last four) XXX-XX-
Street Address:	City, State:		Zip:
Email Address:		Phone: ( ) -	

1. Request Information From (entity who has records**)**
☐ Christie Clinic
☐ Specific provider(s): ____________________________
____
☐ Specific location: ______________________________

☐ Other Organization (fill in **all** blanks below)
Name: ____________________________________
Address: __________________________________
City, State: ________________________________
Phone: ___________________________________
Fax: _____________________________________

2. Provide Information To (who will receive records**)**
☐ Self (Patient)
☐ Christie Clinic, 101 W University, Champaign, IL 61820
Phone: (217) 366-9656 Fax: (217) 366-1294
☐ Christie Clinic, 1401 Eastland Drive, Bloomington, IL 61701
Phone: (309) 663-8311 Fax: (309) 661-3390

☐ Other Person or Organization (fill in **all** blanks below)
Name: ____________________________________
Address: __________________________________
City, State: ________________________________
Phone: ___________________________________
Fax: _____________________________________

3. Information to be Released (check all that apply)

☐ Immunizations	☐ Lab/Path reports	☐ Radiology reports	☐ Other:
☐ Office notes	☐ Diagnostic study reports	☐ Radiology images (CD)	
☐ Operative/Procedure Report	☐ Related to a specific condition: ____________________		☐ Itemized Bills

4. Dates of treatment: From: ____________________ To: ________________________ ☐ Last two years ☐ Most recent

5. Reason for Request

☐ Continuing Care/Treatment		☐ Personal reasons/use	☐ Legal/attorney
Appt date/time: ____________________________________		☐ Insurance/application	☐ Disability/application
☐ Claim payment/billing-related	☐ Social Security Card	☐ Other: _________________________________	

6. Format/Method of Delivery to Recipient **may be processed by third-party copy vendor.*

Electronic: ☐ **My patient portal** – patient use only	Paper: ☐ Fax ☐ Pickup: Clinic site________________________
☐ Secure email ☐ Electronic Media (CD/flash drive)	☐ Mail

7. Notice to Patients (please read):

- Unless you mark the following box, the information to be released may include records related to behavioral health, alcohol and drug abuse treatment, HIV/AIDS, sexually transmitted disease, and genetics. ☐ **I do not want sensitive information released.**
- This authorization is valid for 12 months or until the following specific event or date: ________________________________.
- This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information.
- The provider/facility will not condition treatment on whether you sign this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- **Requests not related to your care*:** You may be charged for copies in accordance with state and federal laws and regulations. You can receive an estimate by contacting the provider or organization releasing the information.

Signature: ______________________________________
Printed Name: ___________________________________
Date Signed: ____________________________________
*Witness: _______________________________________
Date Signed: ____________________________________

*If not signed by the patient, **legal** authority:*
☐ Parent (minor child) ☐ Legal Guardian
☐ HC Power of Attorney ☐ Executor (death cert. required)
☐ Authorized Relative (death cert. & certification form required)

*Witness required for behavioral health records