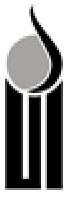

UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT PEORIA

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**INSTRUCTIONS**: Please complete this Authorization in its entirety. You will be billed for copies of medical records according to the limits set by law unless the request is for continuation of care and the medical records are being released directly to another health care provider by the University of Illinois College of Medicine at Peoria. Please address questions about this form to the Department of Pediatrics Medical Records: 420 NE Glen Oak Ave., #201, Peoria, IL 61603; Phone 309-624-9588; Fax 309-624-3273.

Patient Name________________________________________ Date of Birth __________________
Last/First/Middle

I hereby authorize the University of Illinois College of Medicine in Peoria to exchange medical information in written, verbal or electronic form between the two parties listed below:

| **RELEASE TO:** | **OBTAIN FROM:** |
|---|---|
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| PH: __________________________ | PH:__________________________ |
| FAX: _________________________ | FAX:_________________________ |
| | **(Please include name, address, phone and fax #)** |

**INFORMATION REQUESTED:**

☐ Entire Clinic Medical Record Dates:________________________
☐ Other (Specify): ________________________ Dates:________________________

**PURPOSE OF THE DISCLOSURE**:

☐ Physician/Organization for Continuation of Care ☐ Personal Use ☐ Legal
☐ Other (Specify): ______________________________________________

**SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Patient or Patient Representative Initial and Date Required for Each Item):**
**I understand that the records requested above may contain sensitive medical information that requires my specific consent in order to be released. I specifically authorize the release of the following sensitive medical information:**

☐ Mental Health/Developmental Disabilities Initials__________Date__________
☐ Drug/Alcohol Use Initials__________Date__________
☐ AIDS/HIV Initials__________Date__________
☐ Genetic Testing Initials__________Date__________

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:**

- I understand that this authorization is voluntary and that I may refuse to sign it. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

- I understand that I may revoke this authorization, at any time, by notifying the Medical Records office within the Department of Pediatrics in writing at the address listed above. I understand that my later decision to revoke this authorization will not affect any action, use, or disclosure in reliance on this authorization, which cannot be reversed.
- I understand I have the right to inspect and/or receive a copy of the medical information listed above and also receive a copy of this authorization form.
- I understand that the medical information disclosed through this authorization may no longer be protected by federal health information privacy laws. I also understand that sensitive medical information (identified above) disclosed through this authorization may require my additional authorization to be further disclosed.
- I understand this authorization will terminate one year after my date of signature and will not be able to be disclosed beyond this date.

**MINOR PATIENTS 12 – 17 YEARS OF AGE:**

**Please note that the following medical information of a Patient 12 – 17 years of age (Minor Patient) is restricted as follows: Drug/alcohol use, AIDS/HIV, or Birth Control/Sexually Transmitted Disease(s)/Sexual Assault, as well as any health information generated as a result of the Minor Patient's independent legally-authorized consent to treatment, <u>requires the Minor Patient's signature to this release.</u>**
**Mental health or developmental disabilities information is available after the Minor Patient's signature has been witnessed or the Minor Patient's parent or guardian's signature has been witnessed, provided the Minor Patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor Patient's parent or guardian.**

**SIGNATURES:**

| ______________________________ | ______________________________ |
|---|---|
| **Signature of Patient or Patient Representative** | **Date/Time** |

| ______________________________ | ______________________________ |
|---|---|
| **If Signed by other than Patient: PRINT Patient Representative's Name** | **Phone Number** |

______________________________________________________________

**If signed by other than the Patient, please state the Representative's relationship with the Patient and/or the authority of Representative to request information on behalf of the Patient (e.g., Parent, Legal Guardian, Identified Health Care Surrogate, Health Care Power of Attorney, etc.).**

**WITNESS: Please note that a signature of a witness who can attest to the identity of an authorized signatory is required to release any mental health or developmental disabilities information or to revoke any previous authorizations, regardless of the Patient's age. The witness cannot be the same person as the authorized signatory.**

| ______________________________ | ______________________________ |
|---|---|
| **Signature of Witness** | **Date/Time** |

| ______________________________ | ______________________________ |
|---|---|
| **PRINT Witness Name** | **Phone Number** |