DATE PREPARED ____________________

PATIENT ID# ____________________

CARLE MCLEAN COUNTY ORTHOPEDICS
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ________________________________ Date of Birth: ________________
(printed)

Daytime Phone: ________________________ Evening Phone: ______________________________

I authorize Carle McLean County Orthopedics, 1111 Trinity Lane Suite 111 Bloomington, IL 61704; Dr. ____________ to release information from my medical records to (name of entity to receive information):

Name: ____ Phone #: ____________________

Address: ____ Fax #: _____________________

Information to be released: ☐ Complete record(s) **OR** ☐ As indicated below

☐ Progress notes ☐ X-ray/MRI reports ☐ History & Physical ☐ Operation report

☐ Consultation ☐ Physical therapy notes ☐ Other (please specify) ______________________

Date(s) of service: ____

Purpose of release: ☐ Changing Physician ☐ Consultation/second opinion ☐ Legal ☐ Military

☐ Continuation of care ☐ Insurance ☐ Individual request ☐ Disc Other____________________

Please prepare my medical documents to be: ☐ Mailed ☐ Faxed ☐ Patient Pick-Up

I know and accept the information on my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), behavioral or mental health services or treatment for alcohol and drug abuse.

I know and accept that the confidential information released because of this Authorization may be re-released by the recipient and no longer protected under the Privacy Rule.

I know and accept that this Authorization may be cancelled by completing the Authorization Revocation Form at any time unless McLean County Orthopedics has already released information. If not canceled, this consent will expire six months from the date signed.

I know that I have the right to look over the information that I have authorized to be released.

I know and accept that I may refuse to sign this Authorization. I do not have to sign this form in order to receive treatment except in situations where research related treatment is provided or where care is provided solely for the purpose of creating protected health information for disclosure to a third party (e.g. drug screening, fitness for duty examinations, pre-employment or life insurance physicals).

If I do not sign this authorization, no information will be released.

I know and accept there may be a charge for copies of records and X-Rays.

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and/or under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, and under the Illinois HIV/AIDS Confidentiality Act – no such records, nor information from such records may be further disclosed unless the person who consented to third disclosure specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information.

______________________________	______________________	______________
Patient/Representative Signature for **Request**	Relationship – if not patient	Date Requested
______________________________	______________________	______________
Patient/Representative Signature for **Release**	Relationship – if not patient	Date Released
______________________________	______________________	______________
Witness Signature / Date Released	**TYPE OF PHOTO ID**	Amt. & Date Paid