Authorization to Release Behavioral Health Information

ROIR

INSTRUCTIONS *(for internal use)* ☐ Record copy request only ☐ No copies requested, scan only

1. PATIENT INFORMATION

Patient's Name:_____ Birthdate:_____
Street Address:_____
City, State, Zip:_____ MRN:_____
Maiden/Other Names:_____ Phone #: Home (_____)_____ Work (_____)_____

I authorize the use/disclosure of my behavioral health records and/or information as follows:

2.PARTY WHO HAS MY BEHAVIORAL HEALTH RECORDS *(Who Is Sending My Records)*

☐ Carle West Physician Group, Carle BroMenn Medical Center, Carle Eureka Hospital, Carle Cancer Institute of Normal
☐ Other:_____ Phone#:_____
Street Address:_____ City, State, Zip:_____

3.PARTY OR PARTIES WHO I WANT TO RECEIVE MY BEHAVIORAL HEALTH RECORDS *(Who Will Get My Information)*

☐ Carle West Physician Group, Carle BroMenn Medical Center, Carle Eureka Hospital, Carle Cancer Institute of Normal. REQUESTS@RECDEP.COM
☒ Other: RECORDS DEPOSITION SERVICE, INC. Phone#: 248.357.3330
Street Address: PO BOX 5054 City, State, Zip: SOUTHFIELD, MI 48086-5054

4.PURPOSE OF USE/DISCLOSURE OF MY BEHAVIORAL HEALTH RECORDS AND/OR INFORMATION

☐ Medical follow-up ☐ Employment reasons ☐ Underwriting *(insurance)* ☒ Lawsuit
☐ Patient request *(I do not wish to be more specific.)*

5.THE DATES OF RECORDS AND/OR INFORMATION TO BE USED OR DISCLOSED:

☐ Records or information from:_____*(Beginning Date)* to _____*(End Date)*

6.DESCRIPTION OF MY BEHAVIORAL HEALTH RECORDS AND/OR INFORMATION TO BE USED AND DISCLOSED

☐ Hospital Consult-Psychology/Psychiatry/Neuropsychology
☐ Office Visit-Psychology/Psychiatry/Neuropsychology
☐ Hospital Progress Notes-Psychology/Psychiatry/Neuropsychology
☐ Neuropsychological Evaluation
☐ Labs
☐ X-Ray
☐ Billing Records
☐ Other:_____

SPECIALLY PROTECTED RECORDS *(Check and initial the following)*

_____ ☐ Alcohol/Drug Abuse Treatment Records
_____ ☐ Genetics
_____ ☐ HIV

7.EXPIRATION

This authorization will expire on_____Month (MM)/_____Date (DD)/_____ Year (YY)
If no calendar date is specified, information will only be released as of the date this reuqest was received by Carle.

8.CANCELING THIS AUTHORIZATION:

I may cancel this authorization at any time by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to Carle Health Information Management at the address shown on the back of this page. The cancellation will take effect when Carle receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Carle received my letter.

9.RE-DISCLOSURE OF MY HEALTH RECORDS AND/OR INFORMATION:

I understand that the person who receives my behavioral health information, alcohol and drug abuse records or HIV records may NOT disclose it to someone else without my permission, unless permitted by law.

Please turn to the back of this page.

Carle

10. EFFECT OF NOT SIGNING THIS AUTHORIZATION:

I am not required to sign this authorization in order to receive most health care services at Carle. However, I understand that if the ONLY reason I am seeing a Carle provider is to create health information for someone else's use (such as my employer), Carle may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, then I must sign this authorization in order for Carle to perform the pre-employment test.

11.FEES:

I may be charged a copying fee to complete this request. I may ask Carle for a fee estimate. If there is a fee, the bill may come from ScanStat, the company that processes health information requests for Carle. For questions regarding potential fees please contact the Health Information Management department at the number below.

12. RIGHT TO INSPECT & COPY:

I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization.

13. MY AUTHORIZATION:

_____ _____

Signature of Patient 12 years old and over — Date Signed

_____ _____

Signature of Legal Representative or Guardian — Date Signed

_____ _____

Printed Name of Representative or Guardian — Relationship to Patient (Authority to Sign for Patient)

_____ _____

Signature of Witness to Patient's Signature — Date Signed

14.INSTRUCTIONS FOR RECORD COPY REQUESTS ONLY (Check One If Applicable):

☐ Mail record copies out to party or parties I named in #3 ☐ I will pick up records

15. RETURN THIS COMPLETED FORM TO:

Carle BroMenn - Health Information Management
1304 Franklin Ave., Normal IL, 61761
P: (309) 268-5274

16.PROVIDER RELEASE NOTIFICATION: (Office Use Only)

☐ Dr._____ has been notified of this release _____*(initials/date)*

☐ Dr._____ has been notified of this release _____*(initials/date)*

☐ HIM has notified all providers_____*(initials/date)*

☐ Dr._____ has denied this release_____*(initials/date)*

Provide Copy of Signed Form to Patient

Carle