CHRISTIE CLINIC
We listen. We care.

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: ( ) -	

Request Information From

☐ Christie Clinic, 101 W University, Champaign, IL 61820
☐ Specific provider: _____
Phone: (217) 366–9656 Fax: (217) 366-1294
☐ Other Organization (fill in **all** blanks below)
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Provide Information To (Recipient)

☐ Self (Patient)
☐ Christie Clinic, 101 W University, Champaign, IL 61820
Phone: (217) 366–9656 Fax: (217) 366-1294
☐ Other Person or Organization (fill in **all** blanks below)
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Reason for Request

☐ Continuing Care/Treatment
☐ Appt date/time: _____
☐ Claim payment/billing-related
☐ Personal reasons/use
☐ Insurance application
☐ Other: _____
☐ Legal/attorney
☐ Disability application

Format/Method of Delivery to Recipient*

Electronic:
☐ **My patient portal** – patient use only
☐ CD ☐ Flash drive

Paper :
☐ Fax ☐ Mail

**may be processed by third party copy vendor*

Dates of treatment: From: _____ To: _____ ☐ Last two years

Information to be Released (check all that apply)

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

Notice to Patients:

- Unless you mark the following box, the information to be released may include records related to behavior and/or mental health care, 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: _____

If not signed by the patient, legal authority:
☐ Parent (minor child)
☐ Legal Guardian
☐ Health Care Power of Attorney
☐ Executor

Rev 10/2020

CHRISTIE CLINIC
We listen. We care.

Medical Record Release Authorization
Form Instructions

Please complete one form for each requester or recipient.

Section 1: Patient Demographics
Information about the patient to ensure the correct patient is identified by the organization providing the protected health information (medical records, radiology images, bills, etc.).

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: ( ) -	

Section 2: The Sender and the Recipient
Identifies who is to provide the information (sender) and who is to receive it (recipient), including full address, phone number and fax number. For example, protected health information can be sent by Christie Clinic to the patient or another organization. Protected health information can be requested to be sent by another organization to Christie Clinic.

Please be sure to provide complete information, including address, phone, and fax numbers. Do not leave this section blank. When sending records from Christie Clinic, if you specify a provider, only that provider's notes and testing ordered by that provider will be sent.

Request Information From
☐ Christie Clinic, 101 W University, Champaign, IL 61820
☐ Specific provider: _____
Phone: (217) 366–9656 Fax: (217) 366-1294
☐ Other Organization (fill in all blanks below)
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Provide Information To (Recipient)
☐ Self (Patient)
☐ Christie Clinic, 101 W University, Champaign, IL 61820
Phone: (217) 366–9656 Fax: (217) 366-1294
☐ Other Person or Organization (fill in all blanks below)
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Section 3: Reason for Request
Check the box that corresponds to the reason for requesting the protected health information. This information is needed to prioritize requests.

Reason for Request

☐ Continuing Care/Treatment	☐ Personal reasons/use	☐ Legal/attorney
☐ Appt date/time: _____	☐ Insurance application	☐ Disability application
☐ Claim payment/billing-related	☐ Other: _____	

CHRISTIE CLINIC
We listen. We care.

Section 4: Delivery Instructions

Select the format for how the records will be received.

My patient portal: Patient use only. Our fastest method of delivery, we can send any Christie medical records to the patient through their MyChristie patient portal.

CD: The files are burned to a CD. *

Flash drive: Place the files on a portable flash drive. *

Fax: Fax the records to another entity. Size limitations apply.

Mail: Send the records by U.S. Postal Service.

Format/Method of Delivery to Recipient*

Electronic:	Paper :
☐ **My patient portal** – patient use only	☐ Fax ☐ Mail
☐ CD ☐ Flash drive	*may be processed by third party copy vendor

*Christie Clinic utilizes a third party copy vendor to assist with the completion of record requests.

Section 5: Dates of Treatment

Please indicate the specific date or date range of the records being requested. Select "Last two years" if changing providers. This section cannot be left blank.

Dates of treatment: From: _____ To: _____ ☐ Last two years

Section 6: Information to be Released

Please indicate what types of records are to be released. A specific provider or specific condition can also be selected. Radiology images are provided on a CD. This section may not be left blank.

Information to be Released (check all that apply)

☐ Office notes	Specific Provider: _____	☐ Lab/Path reports	☐ Radiology reports
☐ Immunizations	☐ Cardiac study reports	☐ Pulmonary study reports	☐ Radiology images (CD)
☐ Operative/Procedure Report	☐ Related to a specific condition: _____		☐ Itemized Bills

Section 7: Notice to Patients

This section contains important information, including the required statements under HIPAA.

- Select whether to include sensitive information or to withhold it as allowed by law.
- The authorization is valid for 12 months or until a stated specific event. There is no need to add a date here unless the patient wants a specific expiration.
- Steps to revoke this authorization unless it has already been acted upon.
- The provider cannot withhold or refuse treatment on whether you sign.
- Information about re-disclosure of the medical records.

- There may be a charge if the records are not going to another provider. An estimate can be provided by contacting the organization releasing the records.

Notice to Patients:

- Unless you mark the following box, the information to be released may include records related to behavior and/or mental health care, 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.

Section 8: Required Signatures

The patient must sign and date the completed form as well as print their name. If the patient is unable to sign, such as a minor or due to a disability, the person with the legal authority to sign on behalf of the patient should sign. They will need to check the corresponding box which reflects their legal authority and include a copy of the legal documentation that gives them the legal authority to do so, if not already on file with the releasing organization.

Signature: _____ If not signed by the patient, legal authority:

Printed Name: _____ ☐ Parent (minor child) ☐ Legal Guardian

Date Signed: _____ ☐ Health Care Power of Attorney ☐ Executor