Crossing HEALTHCARE

320 E. Central Ave. Decatur, IL 62523 | Phone: 217-877-9117 | Fax: 877-3079

Authorization to Request Release of Health Information

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Reason for Request:

☐ Personal Copy ☐ Continuity of Care ☐ Legal/Insurance

☐ Other (please specify) _____

Send Records By:

☐Mail ☐Fax ☐CD ☐Other: _____

To Request Records from Another Provider/Facility

☐ I authorize Crossing Healthcare to request information from:

Facility/Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

To Release Records to Another Provider/Facility

☐ I authorize Crossing Healthcare to release information to:

Person/Facility/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

Email: _____

Information to be Disclosed: **Dates of Service requested:** ____/____/____ **To** ____/____/____

☐ **Complete Record** (does not include Alcohol/Substance Abuse, HIV/STD, Mental Health or Genetic Records (see separate section below)

- ***OR*** **–** (check individual record types)

☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Immunization Record ☐ Itemized Billing Records ☐ Office Notes

☐ Abstract/ Summary ☐ Prenatal Records ☐ Emergency Room Records- note: record requests only for ER records

☐ Test Result (s) of: _____

☐ Other: _____

I understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/or drug abuse. I authorize the release of all such items marked below. By checking the boxes next to these items I understand that the following information will be released.

☐ Alcohol or Substance Abuse/Use Disorder Records ☐ HIV and/or STD Testing and Results ☐ Mental Health Records ☐ Genetic Records

By signing this authorization form, I understand that: Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations and I was notified in advance of said fees. By submitting this request, I am accepting all associated fees and authorizing the provider/CIOXX to process my request for records. An invoice will be sent to me once the request has been processed.

- I understand that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. The provider/CIOXX has notified me of the risks and will not be held liable if I choose to have my records sent by email.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the facility at which this request is received. Revocation will not apply to information that has already been disclosed in response to this authorization.
- I have a right to inspect and copy the health information disclosed as a result of the delivery of this authorization
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____ **If** I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules.
- If any, Consequences of Failure to consent: _____

_____ _____

Patient or Authorized Representative Signature (12 years and over) Date

_____ _____

Signature of Parent or Guardian and Relationship (if applicable) Date

_____ _____

Witness Signature required to release Mental Health Records Date

_____ _____

Employee Signature Date

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