

# Authorization to Release Behavioral Health Information

**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  
 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  
 Other: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**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      **SPECIALLY PROTECTED RECORDS (Check and initial the following)**  
 Office Visit-Psychology/Psychiatry/Neuropsychology      \_\_\_\_\_  Alcohol/Drug Abuse Treatment Records  
 Hospital Progress Notes-Psychology/Psychiatry/Neuropsychology      \_\_\_\_\_  Genetics  
 Neuropsychological Evaluation      \_\_\_\_\_  HIV  
 Labs  
 X-Ray  
 Billing Records  
 Other: \_\_\_\_\_

**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 request 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.



**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**