Promise Healthcare

Authorize to Release Protected Behavioral Health Information

PERSONAL INFORMATION

Patient Name:_____Date of Birth:___/___/___ SS#: _____-_____-____

Maiden Name or Other Name (s):_____MRN: _____

Address:_____City_____State_____ZIP_____

Phone number: _____(home, cell, other) Email:_____

I Authorize: Promise Healthcare- Health Information Management (HIM)

☐ **To Send to:**
OR
☐ **To Request from:**

_____
Name of Health Care Facility, Physician, Individual, or Agency, etc.

_____
Address

_____ _____ _____
City, State, Zip Phone Number Fax

Method of Release: ☐ Mail ☐ Pick Up at HIM Department ☐ Email _____

***If you choose to receive your health information by email, then there is risk that the information in the email could be read by a third party.**

SPECIFIC RECORDS TO BE RELEASED

☐ All records
☐ Immunization records (specify date):_____
☐ Billing Records (specify dates):_____
☐ Office visit (specify dates and provider):
_____
☐ Labs
☐ Dental ☐ Other (specify):_____
☐ Date(s) of treatment:_____

If you want any of the following health information, then you must check and initial next to the category below:

☐ Alcohol/drug abuse records _____Initials

☐ Genetics _____Initials

☐ HIV/AIDS/Sexually Transmitted Diseases _____Initials

The purpose of this disclosure of information is _____
(i.e., continuing care, Insurance claim, legal counsel, etc.)

- I understand that my medical record may include information relating of sexually transmitted disease, AIDS, HIV, treatment for Alcohol and/or substance abuse
- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not e protected by federal confidentiality rules.
- I understand that I may revoke this authorization at anytime. I understand that if I want to revoke this authorization, I must provide a written revocation to the HIM department of Promise Healthcare. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event _____.If I do not specify an expiration date or event, this authorization will expire on the date of the signature below and records will only be released for services up to and including that date.
- I understand that I am entitled to a copy of this authorization
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.
If the patient is 18 years of age or older, the patient mush sign and date the form.
If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
Please indicate your legal authority and include documentation of your relationship
☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
If the patient is 17 years of age or younger, the patients parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature:_____ Date Signed:_____

Consent expiration date is required if alcohol / drug abuse records are requested: _____

Printed Name of Person Signing (If not patient):_____ Phone#:_____

STAFF USE ONLY

Released by Staff Name:_____ **Type of ID verified:** _____**Date:**_____

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PERSONAL INFORMATION

Staff instructions (for internal use) ☐ No copies requested, scan only ☐ Record copy request only

Patient Name:_____Date of Birth:___/___/___ SS#: _____-_____-____

Maiden Name or Other Name (s):_____MRN: _____

Address:_____City_____State_____ZIP_____

Phone number: _____(home, cell, other) Email:_____

I Authorize the use/disclosure of my BEHAVIORAL HEALTH RECORDS and/or information as follows:

PARTY WHO HAS MY BEHAVIORAL HEALTH RECORDS (WHO IS SENDING MY RECORDS)

☐ Promise Healthcare and any Promise Healthcare Entity
☐ Other:_____Phone#: (_____)_____

Street Address:_____City, State, Zip:_____

PARTY or PARTIES WHO I WANT TO RECEIVE MY BEHAVIORAL HEALTH RECORDS (WHO WILL GET MY INFORMATION)

☐ Promise Healthcare and any Promise Healthcare Entity
☐ Other:_____Phone#: (_____)_____

Street Address:_____City, State, Zip: _____

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

☐ Medical follow-up ☐ Lawsuit ☐ Underwriting (Insurance)
☐ Employment Reasons ☐ Patient Request (I do not wish to be more specific)

THE DATES OF RECORDS AND/OR INFORMAITON TO BE USED OR DISCLOSED:

☐ Records or information from: _____(beginning date) to_____(end date)

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

☐ Office Visit-Psychology/Psychiatry/Neuropsychology
☐ Neuropsychological Evaluation
☐ Labs
☐ Billing Records
☐ Other:_____

SPECIALLY PROTECTED RECORDS

If you want any of the following health information, then you must check and initial next to the category below:

☐ Alcohol/drug abuse records_____Initials
☐ Genetics _____Initials
☐ HIV/AIDS/Sexually Transmitted Diseases _____Initials

EXPIRATION

This authorization will expire on _____/_____/_____(DD/MM/YY). If no date is specified, information will only be released as of the date this request was received by Promise Healthcare.

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 sing it as my witness. The letter must be delivered to Promise Healthcare Information Management at the address shown on the back of this page. The cancellation will take effect when Promise Healthcare Receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Promise Healthcare received my letter.

Mailing address: 819 Bloomington Rd, Champaign, IL 61822 217-356-1558 promisehealth.org

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Patient Name:_____Date of Birth:___/___/___

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.

FEES

I may be charged a copying fee to complete this request. I may ask Promise Healthcare for a fee estimate. If there is a fee, the bill may come from **(name of billing company)** the company that processes health information request for Promise Healthcare. For question regarding potential fees please contact the correspondence department at the number below.

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

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 Date Signed

_____ _____
Signature or Witness to Patients Signature Date Signed

INSTRUCTIONS FOR RECORD COPY REQUEST ONLY (CHECK ONE IF APPLICABLE):

☐ Mail record copies out to party or parties I named in section #3

☐ Will pick up records

RETURN THIS COMPLETED FORM TO:

Promise Healthcare
819 Bloomington Rd
Champaign, Il 61820
217-356-1558

STAFF USE ONLY

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)

Released by Staff Name:_____ **Type of ID verified:** _____**Date:**_____

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