CHRISTIE CLINIC
Medicine for Your Life

VERBAL RELEASE: AUTHORIZATION TO RELEASE MEDICAL INFORMATION, VERBALLY, TO PERSONS INVOLVED IN MY CARE

101 West University Avenue
Champaign, IL 61820
(217) 366-9656
H.I.S. FAX (217) 366-1294

Patient Name _____

Date of Birth ____/____/____ Phone Number _____ History #_____

I hereby give Christie Clinic my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions or updates about my treatment, medications, or condition as requested. The purpose for these disclosures is to enable the persons below to assist me in maintaining my health, and to participate in my medical care..

_____	_____	_____
Name	Relationship to Patient	Phone
_____	_____	_____
Name	Relationship to Patient	Phone
_____	_____	_____
Name	Relationship to Patient	Phone

The patient or the patient's representative must read and initial the following statements:

1. I understand that I may see and receive a copy of this form, if I request it, and that I may get a copy of this form after I sign it. *Initials:*_____

2. **The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, medical correspondence and billing information. If you do not wish such information to be released, do not complete this form.** *Initials:*_____

3. I understand that I may revoke this authorization any time by notifying Christie Clinic in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the revocation. Without express written revocation directed to Christie Clinic, I understand that this authorization will not expire during the remainder of my treatment period with Christie Clinic, and until such time as I present Christie Clinic with a revocation of authorization, or complete a new authorization form. *Initials:*_____

4. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure. *Initials:*_____

_____ _____
Signature of patient or patient's legal representative Date
(Form MUST be completed before signing)

_____
Printed name of patient's representative Relationship to patient

_____
Witness

NOTE TO PATIENT: Based on this completed form, the above-specified individuals will be allowed to obtain your health information verbally from any Christie Clinic facility. Facsimile reproductions of the signature are acceptable. This authorization DOES NOT extend to copies of personal medical records.