CHRISTIE CLINIC
We listen. We care.

Medical Record Release Authorization

For office use:
☐HIS to fulfill
☐Complete/Scan only (faxed)

Completed by:

Date:

Pages:

101 West University Avenue, Champaign IL 61820
Phone: (217) 366-9656 Fax: (217) 366-1294

Please print:

Patient Name (First Middle Last)	Prior names (ex: Maiden)	Date of Birth (MM/DD/YY)	Social Security (Last four) XXX-XX-
Street Address	City, State, Zip		Phone:

Request Information From

☐ Christie Clinic, 101 W University, Champaign, IL 61820
☐ Specific provider: _____
☐ Other
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Provide Information To

☐ Christie Clinic, 101 W University, Champaign, IL 61820
☐ Attn: _____
☐ Other
Name: _____
Address: _____
City, State: _____
Phone: _____
Fax: _____

Reason for Request

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

Information To Be Released (check all that apply)

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

☐ Office notes	☐ Lab reports	☐ Radiology reports	☐ Operative/Procedure Report
☐ Immunizations	☐ Path reports	☐ Radiology images (CD)	☐ Itemized Bills
☐ Other: _____	☐ Diagnostic test (sleep, EKG, etc.) _____		

Method of Receipt

☐ Paper (fax or mail) ☐ CD/DVD ☐ Email* Address: _____@_____

*NOTE: Access may be provided by third party copy vendor only via their portal.

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 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 redisclosure 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/facility 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