Springfield clinic

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH RECORDS

_____ _____ _____ (_____)_____
Name of Patient (Please Print) Date of Birth Maiden Name or Prior Name(s Daytime phone

_____
Address: Street City State Zip

Records from: _____
(Behavioral Health Provider releasing information) Name Address: Street City State Zip

Records to: _____
(Where information may be disclosed) Name Address: Street City State Zip

Why are you asking for this information to be released? (Circle one)
At the request of the individual / Continued Care / Legal / Second Opinion / Transfer / Insurance / Other (Specify):_____

What kind of information do you want disclosed? (***Copy fees may apply including cost of supplies plus actual postage***)

_____ Behavioral Health Notes only Other _____
_____ Information from the most recent 2 years of visits

Dates of service (where the entire record is not appropriate to release): _____

I understand that:

- ✓ I may ask to see and copy the information described on this form. I understand that this authorization will expire on the following specific date, event, or condition related to the purpose of disclosure: _____, and that if no date is indicated here, the authorization will expire 12 months from the date below.
- ✓ I may revoke this authorization at any time by notifying the Springfield Clinic Privacy Officer in writing, but the revocation will not affect any actions which the Clinic may have taken prior to the receipt of the written revocation.
- ✓ Springfield Clinic may not condition treatment, payment, enrollment or eligibility for benefits on whether I do or do not sign this authorization.
- ✓ I hereby authorize the use or disclosure of my individually identifiable health information as described above. I have been made aware that if the receiver re-discloses my information, it may no longer be protected by federal privacy regulations, and that the Springfield Clinic is not liable for any consequences of such re-disclosure.
- ✓ Springfield Clinic will not be responsible for any charges incurred for the reproduction of medical records by another health care provider or its contractors, as a result of this request. Any fees are to be directed to the patient's Responsible Party, if not paid in advance.
- ✓ **The information in my health record may include information regarding mental health, developmental disability, alcohol or drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious diseases, including HIV. Refusal to consent to release of information will result in such confidential records not being released.**

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

Printed name or representative and relationship to patient: _____

Witness (REQUIRED): _____ Date: _____

Facsimile reproductions of the signature are acceptable.

NOTICE: Any information disclosed protected by federal confidentiality rules (42 CFR, part 2) of the Illinois Mental Health and Developmental Disabilities Act (740 ILCS 110/1 st seq.) is **prohibited from further disclosure** unless expressly permitted by the written consent of the person to whom it pertains. **A general authorization for release of medical or other information is not sufficient for this purpose**. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PLEASE see the reverse side (page 2) for IMPORTANT INFORMATION

Springfield clinic

Medical Record Request Processing Fees

Springfield Clinic has partnered with CIOX Health to fulfill your request for a copy of your medical record. Springfield Clinic has chosen to charge our patients discounted rates from the regulated fees in the State of Illinois**.**

Please see details of rates for paper copies for Patient Requests at the Illinois Comptroller's website for Copying Fees Adjustments.

The fee should be remitted to CIOX Health Technologies as directed on the CIOX Health invoice you receive.

Fax or forward this completed authorization for processing to the Correspondence Section, HIM Department. This authorization does not replace the Springfield Clinic's verbal authorization.

Correspondence Fax Numbers: (217) 527-2887 or (217) 527-4748
Correspondence Phone Number: (217) 528-7541 Ext. 43749 or toll free (800) 444-7541 Ext. 43749
Mailing address: Springfield Clinic – Attention: Correspondence, 1025 S. 6th Street, PO Box 19248
Springfield, IL. 62794-9248

Dear Patient:

At Springfield Clinic, we continually strive to better serve our patients. You can assist us in evaluating our endeavors by taking a moment to let us know why you have asked to have your records transferred. Your response is important to us, and is most welcome.

_____ My physician, Dr. _____, is no longer with the Clinic.

_____ I have moved to a new town and will be seeking care there.

_____ I desire a second opinion regarding the proposed treatment.

_____ My insurance no longer covers my doctor's services.

_____ My insurance company has requested that I obtain this information for an application or a claim.

_____ My records are necessary in order to meet school or job-related requirements.

_____ Other: _____

_____

Springfield Clinic is committed to providing quality, caring, ethical, and accessible services through a patient-oriented organization. We continue to diversify our wide range of specialty services in an attempt to provide a full range of medical care. We would welcome any further comments you may wish to make.