MEDICAL HILLS INTERNISTS, LLC
1401 Eastland Drive
Bloomington, IL 61701
P 309-661-3326 F 309-663-1810

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above named person be forwarded.

FROM: Person/Institution: _____
Address: _____
City: _____State: _____ Zip: _____

To: Person/ Institution: _____
Address: _____
City: _____ State: _____ Zip: _____

Date(s) of requested information: _____ to _____
(Date) (Date)

HIGHLY PRIVATE INFORMATION: (This is a required field and t*he patient must complete*)		
Do you authorize release of psychiatric/behavioral information?	**□ Yes**	**□ No**
Do you authorize release of substance abuse information?	**□ Yes**	**□ No**
Do you authorize release of HIV/AIDS information?	**□ Yes**	**□ No**
Do you authorize release of genetic information?	**□ Yes**	**□ No**

Why are you authorizing the release of these records?

□ Transferring Out of Practice □ Insurance Reimbursement □ Personal Review
□ Continued Treatment □ Attorney Request □ Other: _____

Authorization of disclosure will include: (*The patient must check all that apply*)

□ Clinical Summary □ Progress Notes □ Radiology
□ Pediatric Growth Charts □ Pathology Reports □ Stress Test, Holter Monitor, Echo, EKG
□ Immunization Record □ Laboratory □ Other: _____
□ Medication List □ Problem List

I understand that I have the right to inspect a copy of the information to be disclosed. I also understand that I have the right to revoke/withdraw this consent by written statement at any time; otherwise it will automatically expire 90 days from the date of authorization. Information released prior to any revocation/withdrawal is not affected. I understand that information will not be released if I refuse to sign this form, unless instructed or required by law. Disclosure decisions will not cause refusal of treatment.

_____
Signature of Patient or Legal Representative **Date**

_____
(If not signed by the patient, specify relationship to patient)

_____
Witness **Date**

For Office Use Only:

_____ Copies of records Mailed.

_____ Copies of records picked up by patient.
Method of Identification: _____

_____ _____
(Employee's Initials) (Date)