Promise Healthcare

Authorize to Release Behavioral Health Protected Health Information

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.

Promise Healthcare

Behavioral Health Authorize to Release Protected Health Information

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:**_____