

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Name of Patient (Please Print)	Date of Birth	Clinic Number
Maiden Name or Prior Name(s)	Spouse's Name	
Address: Street	City	State
		Zip
		Daytime phone

**Records from:** Springfield Clinic, (circle if applicable)  
1025 South 6th St. P. O. Box 19248  
Springfield, IL 62794-9248

Name of Physician(s)	_____
Street Address	_____
City/State	Zip

**Release to:**

Name _____			
Street	City	State	Zip

Specify reason for disclosure: \_\_\_\_\_  
(such as: Patient treatment, insurance application, second opinion, claim payment, etc.)

The specific type of information to be disclosed is as listed below:

_____ Doctor/Specialty records only	_____ Photographs	_____ Radiology Examinations
_____ Substance Abuse Rx records	_____ Genetic testing	_____ Developmental or adult disabilities
_____ Complete record	_____ Only Immunizations	_____ Correspondence
_____ Other – specify dates of service or other materials to be released: _____		

**The information disclosed may include matters 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.**

**If you do not wish such information to be released, state information to be excluded:** \_\_\_\_\_

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

1. 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 120 days from the date below. I understand that I may revoke this authorization at any time by notifying the Springfield Clinic Privacy Officer in writing, but the revocation will not effect any actions which the Clinic may have taken prior to the receipt of the written revocation. Initials: \_\_\_\_\_
2. 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 Springfield Clinic is not liable for any consequences of such re-disclosure. Initials: \_\_\_\_\_
3. I understand that 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. Initials: \_\_\_\_\_

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

Printed name of representative and relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Upcoming Appointment \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Dr./Phone: \_\_\_\_\_

**NOTICE: THIS AUTHORIZATION IS NOT TO BE USED FOR REPEAT TRANSACTIONS BY LAW.**  
**Clinic Policy prohibits Clinic employees and providers from directly accessing the information specified above. Forward this completed authorization for processing to the Correspondence Section, HIM Department for hard copy records. This authorization does not allow verbal sharing of information by the Clinic Provider offices.**

Facsimile reproductions of the signature are acceptable.

**PLEASE see the reverse side for IMPORTANT INFORMATION**

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.

**FOR OFFICE USE ONLY:**

Received by: \_\_\_\_\_

Forwarded to: \_\_\_\_\_