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McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Medical Records Department
1109 South Lincoln Avenue
Urbana, IL 61801
Phone (217) 265-0798 Fax (217) 244-6495

place label here

Name:

UIN:

Date:

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH CARE INFORMATION

- **Name (Please Print)**_____**UIN**_____

  Date of Birth_____**Current Phone #**_____**Date of Request**_____

- I authorize McKinley Health Center to **release / receive (circle one)** information from my patient records as described below *(specify who records will be sent to or received from):*

  Agency/Facility/Person _____

  Address _____

  City, State, Zip_____

  *Phone #_____ *Fax #_____ *For Health Care Facility Fax Use Only

- **Specific Records to be Disclosed:** ☐ Immunization Records ☐ Clinic Notes ☐ Laboratory Reports
  ☐ X-ray Reports ☐ X-ray Images (Call 217-333-2752 for x-ray image charges) ☐ Allergy Records
  ☐ Physical Exam ☐ Verbal Communication ☐ Other: Specify_____

- **Approximate date(s) of treatment:**_____

- **Purpose of Disclosure:** ☐ Continuing medical treatment ☐ School admission requirements
  ☐ Volunteer Work ☐ Other_____

- **By checking the box or boxes below, you are authorizing the release of the following information:**
  - ☐ HIV/AIDS (as defined by Illinois Statute) – **will not be released unless specifically indicated.**
  - ☐ Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations – **will not be released unless specifically indicated.**
  - ☐ Mental Health information (as defined by Illinois Mental Health and Developmental Disabilities Confidentiality Act) – **will not be released unless specifically indicated.**

- **I UNDERSTAND THE FOLLOWING PROVISIONS:**
  - I have the right to inspect and receive copies of information to be disclosed.
  - I have the right to revoke this consent at any time.
  - Revoking this consent shall have no effect on disclosures made before the revocation of consent.
  - Any revocation of consent must be submitted in writing to the Medical Records Unit and signed by the person who gave the consent.
  - The confidential information disclosed and used pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by law.******
  - It has been explained to me that if I refuse to consent to this disclosure of information, the following are the consequences:
    _____(specify if any)
  - **This authorization expires 90 calendar days after it is signed** or upon the following specific date, event or condition:
    _____

- Signature of Patient or Consenting Individual_____Date_____

  If signature is not of Patient, indicate relationship_____

  Signature of Witness_____Date_____

******NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any records disclosed pursuant to said Act unless the person who consented to this disclosure specifically consents to such redisclosure.

For Office Use Only ☐ **Mail** ☐ **Pick-up (date _____)** ☐ **Fax** ☐ **RUSH** **Appt Date**_____

RECORDS COMPLETED: Method: 1) Mailed, 2) Hand Carried, 3) Faxed, 4) Messenger, 5) X-ray images hand carried, 6) Reviewed records

# pages	Date	Method	Init	# pages	Date	Method	Init	# pages	Date	Method	Init

MH/3rd party review: ☐**Approved** ☐ **Not approved** **Signature**_____**Date**_____

12/13/16:ms