Mid-Illinois Hematology and Oncology Associates, Ltd.

Phone Number: 309-452-9701 Fax Number: 309-454-1957

PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Name: _____ Date of Birth: _____

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

From: Person/Institution: _____

Address: _____

Phone Number: _____ Fax Number: _____

To: Person/Institution: _____

Address: _____

Phone Number: _____ Fax Number: _____

Date(s) of requested information: _____ to _____ or ____ All dates of service

The purpose of this use of disclosure is as follows:

____ Transferring Out of Practice ____ Attorney Request ____ Insurance/Disability

____ Continuation of Care ____ Personal Review

____ Other: _____

Authorization of disclosure will include (check all that apply):

____Complete Chart ____ Office Notes ____ Hospital Notes

____ Radiology Scans ____ Bone Marrow Reports ____ Labs

____ Treatment Records ____ Other, please specify: _____

Do you authorize release of psychiatric/behavior information? _____Yes _____No

Do you authorize release of substance abuse information? _____Yes _____No

Do you authorize release of HIV/AIDS information? _____Yes _____No

Please note:

It is the office policy to only provide the protected health information that is ordered by our physicians. For protected health information ordered by physicians other than those affiliated with this office, you must contact that physician's office. This authorization is valid for 3 months from the signed date at the bottom. I understand that I may revoke this authorization in writing to Mid-Illinois Hematology and Oncology Associates, Ltd at any time during the 3 month period. I understand that the information disclosed may be further disclosed by the above named third party or parties and that it may no longer be protected by the Final Privacy Rule. I understand that I have the right to refuse to sign this authorization and that my treatment, payment of my health care, and health care benefits will not be affected if I do not sign this form.

Signed: _____ Date: _____

Specify relationship to or authority to act for, Patient (if applicable):_____

Print name of individual or legal representative (if applicable):_____

****Please see other side regarding our policy for medical records****

To Our Patients:

We understand that your medical records are of great importance to you as a patient here at Mid-Illinois Hematology and Oncology Associates. You may be charged a minimal fee when requesting your records. You will receive a bill for the records within 4-5 business days via the mail. Once the bill is paid in full, the release for records will be processed. The law allows 30 days for processing of your request; however, our general turnaround time is 10-15 business days for processing of all requests.

Please complete the attached Protected Health Information Release form in its entirety. We ask that you please state the purpose for your request, as well as to whom the information is being sent, including all contact information.

Also, please be aware that our policy is to only release information that is ordered by our physicians. Other information ordered by physicians not affiliated with our office will have to be requested from the office or hospital from which they originated. For a complete copy of your records you are encouraged to obtain copies from each office you have visited.

Thank you for your cooperation and understanding.

Sincerely,

Medical Records Department

Mid-Illinois Hematology and Oncology Associates, Ltd.