

Authorization Instruction Sheet

1. Only **one** patient per Authorization can be accepted.
2. Only **one** recipient per Authorization can be accepted.
3. All parts of the authorization **must** be filled out. See below for specific instructions:

Page 1

- Fill in the name of the facility or doctor where the records are being released **from**.
- Fill in the Patient's name and date of birth. The last 4 of the social security numbers need to be filled in.
- Fill in the name of who is receiving the records.
- Fill in the address of where the records are being released.
- Remember to **always** note the phone number (with area code).
- Please provide a fax number, if available.
- Mark the box indicating how the information is to be sent.
- If you would like the records to be emailed, please provide the email address in the space provided.
- Mark the purpose for the disclosure (i.e. if you are seeing another doctor – mark continuing care).
- Fill in the dates of treatment of the records you are requesting.
- Mark what records you would like to be released.

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- If you wish to restrict sensitive information, please list your restrictions in the space provided.
- Expiration date section: If no date is noted the authorization will expire in 60 days. A date may be filled in up to ONE year from the date signed. **Make sure the expiration date is not the same as the date of the signature at the bottom of page 2.**
- If you have an upcoming appointment at the facility where your records are being released, please note the date.
- The patient/ patient representative signs **and** dates on the signature and date lines. If signing as a representative, please provide accompanying legal paperwork authorizing a legal representative. **NOTE: Electronic Signatures are NOT allowed.**
- If you are the witness, sign **and** date the area under the patient's signature. A witness signature is **not** required.

Please fax the authorization back to: **833-776-3635** or mail in the original to: **Prairie Cardiovascular Consultants, ATTN: HIPAA Department, 619 East Mason, Springfield, IL 62701. P: 217-788-0706**