



**PMG Research of Christie Clinic, LLC**  
**Medical Records Release Form**  
**101 West University Avenue**  
**Champaign, IL 61820**

**Office: 217.366.1327 Fax: 217.366.5367**

**Authorization for Use and Disclosure of Protected Health Information**

Patient Name: \_\_\_\_\_  
Last First Middle/Maiden

Address: \_\_\_\_\_  
Street Address City State Zip Code

Date of Birth: \_\_\_\_\_

**Authorization:** I voluntarily authorize and direct PMG Research of Christie Clinic, LLC (“PMG”) to use and disclose my health information specified below to the following Primary Care Physician or Recipient:

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Recipient’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

PMG may release information to these Family Members I authorize: \_\_\_\_\_

**Purpose or Need for Disclosure.** (Check applicable categories).

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Further Health Care | <input type="checkbox"/> Insurance/Claims | <input type="checkbox"/> Application for Insurance |
| <input type="checkbox"/> Legal               | <input type="checkbox"/> Personal         | <input type="checkbox"/> Disability                |
| <input type="checkbox"/> Academics           | <input type="checkbox"/> Other: _____     |  |

**Information To Be Disclosed:** This Authorization permits PMG to disclose the following health information. **PLEASE INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE:**

- \_\_\_\_ All of the medical records that PMG has in its possession.  
\_\_\_\_ All of my medical records except for the following: \_\_\_\_\_  
\_\_\_\_ Only the following records or types of health information: \_\_\_\_\_



**Re-disclosure:** I understand that once PMG discloses my health information to the Physician or Recipient identified above, PMG cannot guarantee that the Physician or Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

\_\_\_\_\_ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment**, I hereby authorize the release of such information.

\_\_\_\_\_ I understand that if my record contains **confidential HIV related information**, I hereby authorize the release of such information. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

**Term of this Authorization:** This Authorization will remain in effect:  
(To be completed by patient.)

- From the date of this Authorization until one year after the study completes.
- From the date of this Authorization until the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.
- Until PMG fulfills this request.
- Until the following event occurs: \_\_\_\_\_.

**Refusal to sign/Right to Revocation:** I understand that I may refuse to sign or that I may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

**Revocation:** I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to PMG at the address listed below. The revocation will be effective immediately upon the receipt by PMG of my revocation, except that the revocation will not have any effect on any action taken by PMG in reliance on this Authorization before it received my written notice of revocation.

PMG Research of Christie Clinic, LLC  
101 West University Avenue  
Champaign, IL 61820  
Office: 217.366.1327 Fax: 217.366.5367

**Questions:** I may contact the Privacy Officer for answers to my questions about the privacy of my health information. The Privacy Officer can be reached by phone at (336) 608-3500 and ask for the Privacy Officer or email at [privacyofficer@pmg-research.com](mailto:privacyofficer@pmg-research.com).



**Signature:**

\_\_\_\_\_  
Research Participant's Signature

\_\_\_\_\_  
Date

If the Research Participant's is unable to sign this Authorization, I am the Legally Authorized Representative and have the authority to sign this Authorization.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Legal Relationship

\_\_\_\_\_  
Date

Witness Signature (applicable only if the Research Participant or the Legally Authorized Representative signs with the letter "X")

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date