Patient Name_____ Date of Birth_____

Address_____ Medical Record Number_____

Phone Number_____

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION (evaluation, diagnosis, testing and /or treatment for alcohol and/or drug abuse [federally assisted programs], HIV or AIDS and mental health).

I hereby authorize that such health information regarding the above-named person be forwarded:

FROM: Person/Institution_____

Address_____

City_____State_____Zip_____

TO: (**Recipient**) Person/Institution_____

Address_____

City_____State_____Zip_____

Purpose or need for information:_____

Disclosure will include the following verbal or written information: (*check all that apply*)

❒Face Sheet ❒History & Physical ❒Laboratory/Diagnostic Testing Results ❒School Information
❒Discharge Summary ❒Medication Records ❒ Behavior Health/Psychological Consult ❒Psychological Evaluation/Testing Results
❒ER Record Report ❒Psychiatric Evaluation ❒Psychosocial Assessment ❒Summary of Treatment Records and contact dates
❒Substance Abuse Treatment Record ❒HIV Test Results ❒Other _____

Records for the period (dates) from _____to_____

I have a right to inspect and copy the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

EXPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date _____/_____/_____.

_____ _____
Signature of Patient **Date**

OR

_____ _____
Signature of Parent/Guardian/Legal Representative **Date**

_____
Relationship to the Patient (See Back of Form)

_____ _____
Witness **Date**

REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.

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AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION

Patient Label

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00-5019 09/09

WHO MAY AUTHORIZE RELEASE

Mental Health:

1. A patient, 12 years old or older.

2. The parent or guardian of patient under 12 years old.

3. The parent or guardian of a patient who is at least 12 years old but under 18 years old, if the patient is informed and does not object or if the therapist finds that there is no compelling reason for denying the access. A parent or guardian who is denied access may petition the court for access to the record. In addition, not withstanding the above, a parent or guardian of a patient who is at least 12 years old but under 18 years old may request and receive the following information: current physical and mental condition, diagnosis, treatment needs, services provided and services needed, including medication, if any.

4. The guardian of a patient who is 18 years old or older.

5. An attorney or guardian ad litem representing a minor age 12 or older in a judicial or administrative proceeding, as long as the attorney or guardian has a court order allowing access to the patient's mental health record.

6. An agent holding a patient's power of attorney for health care or property when the power of attorney authorizes the access to the patient's records.

Substance Abuse/Treatment and HIV and/or AIDS:

1. Minor (if minor consented to treatment)

2. Parent

3. Guardian

4. Agent under Power of Attorney for health care

5. Health Care Surrogate

Patient Name_____ Date of Birth_____

Address_____ Medical Record Number_____

Phone Number_____

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City_____State_____Zip_____

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❒Face Sheet ❒History & Physical ❒Laboratory/Diagnostic Testing Results ❒School Information
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❒ER Record Report ❒Psychiatric Evaluation ❒Psychosocial Assessment ❒Summary of Treatment Records and contact dates
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Records for the period (dates) from _____to_____

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Signature of Parent/Guardian/Legal Representative **Date**

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