Patient Nan	Patient Name		Date of Birth		
Address		Medical Record N	Medical Record Number		
Phone Num	ber				
		LY CONFIDENTIAL HEALTH INFORM y assisted programs], HIV or AIDS and 1	MATION (evaluation, diagnosis, testing and /or nental health).		
I hereby au	horize that such health information regar	ding 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:				
□Face Sheet	ary	oratory/Diagnostic Testing Results Sch navior Health/Psychological Consult Psy chosocial Assessment Su			
Records for the per	iod (dates) from	to			
			ation, the institution named above will not release my healt o allow my health information to be used and disclosed to		
	-	ease this information. This Authorization sl ar from the date signed unless I fill in an ear			
Signature of Pat	ient		Date		
OR					
Signature of Par	rent/Guardian/Legal Representativ	/e	Date		
Relationship to t	he Patient (See Back of Form)				
Witness			Date		
abuse information I from making any fu prohibits the redisc	has been disclosed from records whose co orther disclosure of this information except	SE OF HIGHLY	epresentative signing this Authorization that substance ederal regulations (42 CRF Part 2) prohibit the recipient tt. Notice is hereby given to the recipient that Illinois law further authorization.		
* 0 0 5			00-5019 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

Discharge Summary DMediciation Keendes ER Record Report DPsychological Consult OPsychological Consult OPS Consultation Consult OPS Consultation Consult OPS Consul	Pines Number The Standard of dring about fielderally assisted programs, HW of ADDs and metral health. Pines Number Matternant for alcolol and/or dring about fielderally assisted programs, HW of ADDs and metral health. Pines Number Pines Numer <th>Patient Nat</th> <th colspan="2">Patient Name I</th> <th colspan="2">Date of Birth</th>	Patient Nat	Patient Name I		Date of Birth	
ALTIONELTION FOR RELEASE OF INCIDENT SETURATION TICK THAT HAN THIS NORMATION, disposes, testing and or traditional divergences and operangences and operangence	ATHOREZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION (relutation, diagnosh, testing and or tentiment for alcohol and/or drug abuse [federally assided programs], IIIV or AINS and mental beath). Thereby authorite that such health information regarding the above-named person be forwarded: FIOT: Person fination: 	Address		Medical Record N	Medical Record Number	
treatment for skelold and/or drug abase (federally assisted programs), HV or AIDS and mental health). Thereby suthorize that such health information regarding the above-samed person be forwarded: FROM: Person Institution. Gity	Treatment for alcohol and/or drug abuse (foderally assisted programs), HIV or ADS and mental health. Thereby authorize that such health information regarding the above-numed person be forwarded: FROM: Person Institution. City	Phone Nun	nber			
FROM: Person Institution	FROM: Person flastitution Address					
Address	Address	I hereby au	thorize that such health information regarding the above-name	ed person be forwarded	:	
Ciy	City	FROM:	Person/Institution			
To: Person /Institution	TO: reson/institution		Address			
(Recipien)	(Recipient) Address		City	State	Zip	
Address	Address		Person/Institution			
<pre>urpses or need for information:</pre>	proper or need for information: actionare will include the following verbal or written information: (<i>check all that apply</i>) The Shift of The Shif	(Recipient)	Address			
Disclosure will include the following verbal or written information: (<i>check all that apply</i>) Face Shert Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will include the following verbal or written information: Disclosures will information will not refuse to recease and if 1 do not sign this Authorization shall remain valid unless revoked. XPIRATION DATE: This release is valid for one (1) year from the date signed unless 1 fill in an early date	Assure will include the following verbal or written information: (check all that apply) Face Sheet manual History & Physical Checken and Physical Evaluation Testing Results Checken and Person/Institution will not refuse to treat me based on whether 1 agree to allow my health information to be used and disclosed there. The above named person/Institution will not refuse to treat me based on whether 1 agree to allow my health information to be used and disclosed there. The above named person/Institution will not refuse to treat me based on whether 1 agree to allow my health information to be used and disclosed there. The above named person/Institution will not refuse to treat me based on whether 1 agree to allow my health information to be used and disclosed there. The above named person/Institution will not refuse to treat me based on whether 1 agree to allow my health information to be used and disclosed there. The above named person/Institution will not refuse to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care test to the extern that action has already been taken to release this information. 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 test to the extern that action has already been taken to release this information. The above named person/Institution will not every this period. The above and person frame term at the above and the person term at the above and		City	State	Zip	
Fine Sheet Distortery Summary Discharge Summary Distortery Summary of Preschiatric Records Discharge Summary Discharge Summary of Treatment Records and contact dates Distortery Summary of Treatment Records Distortery Summary of Treatment Records and contact dates Distortery Summary of Treatment Records Distortery Summary of Treatment Records and contact dates Distortery Summary of Treatment Records Distortery Summary of Treatment Records and contact dates Distortery Summary of Treatment Records Distortery Summary of Treatment Records and contact dates Distortery Summary of Preschiatric Summary of Treatment Records and contact dates Distortery Summary of Treatment Records and contact dates 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 car except to the extent that action has already been taken to release this information. This Authorization shall certain valid unless revoked. XPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date	Face Sheet	urpose or need fo	r information:			
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 I formation. 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 there. 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 ear except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. EXPRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date	ave 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 refease the hormation. 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 exceed the action has already been taken to release this information. This Authorization shall remain valid unless revoked. KPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date/	□Face Sheet □Discharge Sumn □ER Record Repo	□History & Physical □Laboratory/Diagnostic T hary □Medication Records □Behavior Health/Psycho hary □Psychiatric Evaluation □Psychosocial Assessmer	esting Results	chological Evaluation/Testing Results nmary of Treatment Records and contact dates	
iformation. 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 thers. 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 car xcept to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. XYIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date ignature of Patient Date ignature of Parent/Guardian/Legal Representative Date ignature of Patient (See Back of Form) Date Witness Date REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance base information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF) Par 12 prohibit the recipier on making any further disclosure of any health information regarding HIV and mental health treatment without further authorization. inothists the redisclosure of any health information regarding HIV and mental health treatment without further authorization. Patient Label	formation. 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 theres. Iso 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 cept to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. KPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date/	Records for the per	riod (dates) from	to		
xcept to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. XXPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date	eept to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.					
OR Date ingnature of Parent/Guardian/Legal Representative Date Relationship to the Patient (See Back of Form) Date Witness Date REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance to buse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipier tom making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois I rohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization. Image: Advocate Health Care Constitution of the patient of the patient Label Patient Label	R gnature of Parent/Guardian/Legal Representative Date elationship to the Patient (See Back of Form) 'itness Date EDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance use information has been disclosed from records whose confidentiality is protected by Federal regulations (42 CRF Part 2) prohibit the recipient making any further disclosure of this information eregarding HIV and mental health treatment without further authorization. * Advocate Health Care * AUTHORIZATION FOR RELEASE OF HIGHLY * CONFIDENTIAL HEALTH INFORMATION * Patient Label					
Relationship to the Patient (See Back of Form) Date Witness Date REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance buse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipien room making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois Level is hereby given to the recipient that Illinois Level * Mathematical Advocate Health Care * Advocate Health Care * AUTHORIZATION FOR RELEASE OF HIGHLY Patient Label * ONFIDENTIAL HEALTH INFORMATION Patient Label	elationship to the Patient (See Back of Form) 'itness Date EDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance use information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient on 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 obligs of any health information regarding HIV and mental health treatment without further authorization. * Authorization FOR RELEASE OF HIGHLY Patient Label * ONFIDENTIAL HEALTH INFORMATION Patient Label	DR				
Witness Date REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance buse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipier rom making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois In romanian any health information regarding HIV and mental health treatment without further authorization. * Mathematical Constraint of the patient of the patient of the patient information regarding HIV and mental health treatment without further authorization. * Mathematical Constraint of the patient of the patient of the patient of the patient information regarding HIV and mental health treatment without further authorization. * Mathematical Constraint of the patient of the patient of the patient of the patient has the patient of the pati	Zitness Date EDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance use information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient on making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois has been disclosed from records whose confidentiality and mental health treatment without further authorization. Image: Advocate Health Care Image: Advocate Health Care Image: Advocate Health Information FOR RELEASE OF HIGHLY Patient Label	Signature of Parent/Guardian/Legal Representative			Date	
REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance buse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipier rom making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois is rohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization. * Advocate Health Care * AuthORIZATION FOR RELEASE OF HIGHLY • ONFIDENTIAL HEALTH INFORMATION * Patient Label	EDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance use information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient on making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois has been disclosed from records whose confidentiality and mental health treatment without further authorization.	Relationship to	the Patient (See Back of Form)			
buse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipier rom making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois I rohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.	use information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient on 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 oblibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.	Witness			Date	
AUTHORIZATION FOR RELEASE OF HIGHLY ○ CONFIDENTIAL HEALTH INFORMATION Patient Label ○	AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION Patient Label	buse information from making any f	has been disclosed from records whose confidentiality is prote arther disclosure of this information except with specific write	cted by Federal law. F en consent of the patien	ederal regulations (42 CRF Part 2) prohibit the recipient t. Notice is hereby given to the recipient that Illinois law	
• CONFIDENTIAL HEALTH INFORMATION Patient Label • •	CONFIDENTIAL HEALTH INFORMATION Patient Label Patient Label					
		□ CON □			Patient Label	