

Printed Patient Name:	Date of Birth:
Address:	Telephone Number: ()
City: _____ State: _____ Zip Code: _____	

I hereby authorize _____ (facility name) to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:

Provider Name/Organization/Individual _____

Full address of Provider/Organization/Individual _____

City: _____ State: _____ Zip Code: _____ Telephone #: ()

Including information related to: Psychiatric Care & Treatment Substance Abuse Care & Treatment Medical Care & Treatment

For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use Follow-up Care Tuition Payment
 Placement Insurance Determination Vocational Service Referral Continuity of Care At Request of the Individual
 Other(Specify) _____

Treatment date(s): _____ Expiration Date or Event: _____
 Expiration Date: (Calendar Date/If No Calendar Date Stated Information May Be Released Only On The Day the Consent Form Is Received)

INFORMATION TO BE DISCLOSED:

<input type="checkbox"/> Dates of Admission & Discharge	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Speech & Language Eval.
<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Attendance
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Medication Information
<input type="checkbox"/> Physical Health Screen	<input type="checkbox"/> Psychosocial Assessment	<input type="checkbox"/> Treatment Update	<input type="checkbox"/> Other(Specify)
<input type="checkbox"/> Consultation			

HIV Documentation _____ (Must Initial)

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.
- The Consequences of my refusal to sign, if any are: _____

(Signature of patient) _____ (Date) _____ (Signature Parent or Legal Representative) _____ (Date)

(Witness Signature) _____ (Date)

(Patients 12 to 17 years of age must sign in addition to the Parent or Legal/Personal Representative)
 (If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR#: _____

When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian Power of Attorney Executor of Estate Other: _____

Person/Department completing the request: _____

Authorization to Disclose Protected Health Information

- Alexian Brothers Behavioral Health Hospital
1650 Moonlake Blvd.
Hoffman Estates, IL 60194
- Alexian Brothers Behavioral Health Group Practice
1786 Moonlake Blvd.
Hoffman Estates, IL 60194



- Alexian Brothers Northwest Mental Health Center
1606 Colonial Parkway
Palatine, IL 60067