CentegraHealthSystem

BEHAVIORAL HEALTH AUTHORIZATION TO DISCLOSE AND/OR OBTAIN HEALTH INFORMATION

Patient Name: X ____________________________
Last First M.I.

Date of Birth: X __________ S.S. #: X __________________ Telephone: X __________________

The undersigned hereby authorizes and requests:

Horizons Behavioral Health Individual/Institution/Agency	To disclose to or obtain from:	X Individual
527 W. South St. Street Address		Institution/Agency
Woodstock IL 60098 City State Zip Code		Street Address
		City State Zip Code
		Phone Fax

✓Check the following:

____ **All Medical Records** ____ **Phone Conversation** ____ **Pre-Surgery Evaluation** ____ **School**

Letter needed, specify the following: ____ **applying for disability** ____ **return to work** ____ **utility company**

____ **Other:** ____

Type of healthcare encounter: **Behavioral Health** **Date(s) From:** **1st Visit** **To:** X ____________*

***Release only those records from the dates specified above**

This information about me may be transmitted verbally, in writing, and via facsimile to the receiving individual/institution/agency.

I fully understand the following: My medical record and/or information in connection with the hospitalization/treatment date(s) stated above may contain mental health and developmental disabilities, and/or alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results. The medical records and/or healthcare information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required or permitted by law. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may not be covered by law. Centegra Health System is not responsible for any re-disclosures of health information or medical records. I may inspect and arrange for photocopies of the records/healthcare information that are to be disclosed. I understand I may be responsible for costs associated with obtaining a copy of my records.

THIS AUTHORIZATION EXPIRES ONE (1) YEAR FROM THE DATE OF SIGNATURE.
I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the CHS facility where I signed my authorization. If I refuse to sign this authorization, my medical records/health information will not be released. I understand that if this authorization is for the purposes of third party payment to Centegra Health System that diagnostic and therapeutic information as may be necessary to process benefits will be disclosed to my insurance company and/or the insurance company's review agency, and that refusal to authorize information for this purpose will result in the assignment of financial responsibility to me for these services. No other adverse consequences to me will result if I refuse to sign this authorization. After signature by myself and a witness, I may take a copy of this Authorization for my personal records.

PATIENT/AUTHORIZED SIGNATURE X ______________________________ DATE X __________
(If other than patient, state relationship)

WITNESS SIGNATURE X ______________________________ DATE X __________

CO-SIGNATURE X ______________________________ DATE X __________
(Relationship to Patient) Ages 12-17: Patient, parent (legal guardian), and witness must sign and date.

Notice to receiving agency: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to re-disclosure.
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.