

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

I hereby authorize _____ to release and exchange written, oral or electronically transmitted (facility name) 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
 Primary Care Physician 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 FACILY 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 60169
 Alexian Brothers Behavioral Health Group Practice
 1786 Moonlake Blvd.
 Hoffman Estates, IL 60169
**White Copy-Chart Yellow Copy-Patient
 Pink Copy-Mail Out Request Records**



ALEXIAN BROTHERS
Health System

Authorization to disclose PHI
 Form # 9060-010 (6/03) Page 1 of 1