AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Full Name: _____ Date of Birth:_____ Phone Number:_____

Address:_____

I hereby authorize: **release information to:** ◯ **exchange information with:** ◯

NAME: Spectrum Behavioral Health	**NAME:**
ADDRESS: 2081 Calistoga Dr., Suite 2S	**ADDRESS:**
New Lennox, IL 60451	
PHONE: 815-418-6070 FAX: 779-803-3119	**PHONE: FAX:**

The following information is requested: (patient* or legal guardian √ items to be released).

- ☐ Dates of Service
- ☐ Psychiatric Evaluation & Treatment
- ☐ Mental Health Treatment Plan
- ☐ Substance Abuse Assessment/Treatment
- ☐ HIV Status, Test Results, & Treatment
- ☐ Summary of Contacts
- ☐ Practitioner Progress Notes
- ☐ Medication Records
- ☐ Psychological Test Reports
- ☐ Medical History, Diagnoses, & Treatment
- ☐ Discharge Plan/Summary
- ☐ Financial Account information
- ☐ Other (specify)_____ _____ _____

The Purpose or Need for Disclosure is:

- ☐ For Continuity of Care
- ☐ To Transfer Client Care
- ☐ For Follow Up Care
- ☐ To Aid in Treatment
- ☐ To Inform Family
- ☐ Legal/Court System
- ☐ Referral Source
- ☐ For Discharge Planning
- ☐ To Update Medical Records
- ☐ Employer
- ☐ Application for Provider Coverage
- ☐ Psychological Report
- ☐ To Aid in financial account activity
- ☐ Other (specify) _____ _____

Disclosure Format (Paper/US Mail or Fax is default if not marked.):

- ◯ Paper/US Mail
- ◯ Facsimile/E-Fax
- ◯ Email
- ◯ Verbal
- ◯ Other (specify) _____

This authorization is voluntary and valid for one year (some state statutes may vary), and then automatically expires.

- I may revoke this authorization at any time. **Revocations to this authorization must be presented in writing**. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantage of disclosing such information. I hereby release above entity, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I understand that I have a right to receive a copy of this authorization. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method for any permissible purpose. I understand that I have the right to refuse to sign this authorization and that the only consequence is that no information will be exchanged.

_____ _____ _____

Client (Age 12-and over) Parental Signature if resident is 17 or younger Date

_____

Signature of Witness (if necessary)

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.