STREAMWOOD BEHAVIORAL HEALTHCARE SYSTEM
AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:
If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or 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 use or 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.

I hereby authorize: STREAMWOOD BEHAVIORAL HEALTHCARE SYSTEM
1400 E. Irving Park Road, Streamwood, IL 60107-(800) 272-7790

To use or release health information and records obtained during the course of treatment of:

Patient Name: _____ Date of Birth: _____

Address:_____ Patient's Phone: _____

_____

1. The information is to be used or disclosed to the following persons or organizations:

   Person/Entity Name: _____

   Address: _____

   _____

   Phone: _____

2. Purpose: The purpose of the use or disclosure is for:

   ☐Treatment, Payment, and/or Operations Processes

   ☐At the request of the parent and/or legal guardian

   ☐Other: _____

3. Persons authorized and information to be used or disclosed:

The information to be used or disclosed by SBHS treatment providers, Health Information Services staff or Community Liaisons includes only those items checked below, with respect to services provided on or around (insert dates of service):_____. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, Sexually Transmitted Disease, HIV/AIDS test results or diagnoses. The information to be used or released includes:

_____Discharge Summary
_____ Transition Record:
(Discharge Order/Discharge Plan-Parts I-III,
Safety Crisis Plan, Advance Directive
_____Aftercare Providers
_____Integrated Assessments:
(A&R, Nursing, Social Service)
_____Psychiatric Evaluation
_____Physician Orders
_____Physician Progress Notes
_____Therapist/Social Services Progress Notes
_____Nursing/Behavioral Technician Progress Notes
_____Treatment Plans
_____Other: _____

_____Laboratory/EEG/EKG Data
_____Psychological Testing
_____History and Physical Exam
_____Consultation Reports
_____Education-Progress Notes
_____Education-School Assignments
_____Medication Records
_____Consent Forms
_____Advance Directives/Legal Paperwork
_____Verbal Communication- No Restrictions
_____Verbal Communication Restrictions:
_____Limited to Checked Areas Above
_____ Restrictions- Specific Individuals or
Departments: _____
_____

Patient's Name _____

Person/Entity Name (Where/Whom To Disclose):_____

This authorization is limited to only that information that I have requested above to be used or disclosed to the person/facilities named herein. I hereby release Streamwood Behavioral Healthcare System from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If patient is a minor, relevant state law should be followed with respect to the required signators. Streamwood Behavioral Healthcare System will not condition treatment, payment or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Streamwood Behavioral Healthcare System will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):
   - ☐ The patient, and the identification that I have provided is true and correct.
   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: "_____".
5. **Revocation:** I have the right to stop the use or release of information at any time (in writing), although I understand that I cannot do anything about information already used or disclosed under this authorization or used as a condition of obtaining insurance coverage.
6. **Copy:** I understand that I will receive a copy of this completed form.
7. **Inspect and Copy:** I fully understand that I have the right to inspect and copy the information to be disclosed.

_____	_____	
(Date)	(Patient Signature – *Patient age 12 or over*)	
_____	_____	_____
(Date)	(Witness to Patient Signature)	(Printed Name)
_____	_____	_____
(Date)	(Personal Representative Signature) (*Parent or Guardian or DCFS Authorized Agent*)	(Printed Name)
_____	_____	_____
(Date)	(Witness to Personal Representative Signature)	(Printed Name)

(INTERNAL USE ONLY)

☐ Patient refused signature upon admission. ☐ Patient is unable to sign upon admission.

☐ Signature is absent, however, verbal consent has been obtained.

☐ Parent/Guardian Verbal Consent ☐ Patient Verbal Consent

☐ Parent/Guardian Printed Name: _____

_____ _____

(Signature of Staff) (Date Consent Received)

(HEALTH INFORMATION SERVICES)

I have received _____ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

_____ _____ _____

(Employee Signature) (Printed Name) (Date)

DISTRIBUTION: Original: Chart Yellow: Patient/Parent/Guardian