Streamwood Behavioral Healthcare System
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Last 4 of SS#: _____

Current Address: _____ Current Phone #:_____

To be released to or requested from:
☐ Self (address above)
☐ _____ (____)_____ _____
Agency/Organization Telephone Number Street Address
_____ (____)_____ _____
Name / Attention to Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: _____
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose: ☐ Continuing Care ☐ Billing/Insurance
☐ Child Custody ☐ Personal Use ☐ Academic ☐ Legal Investigation ☐ Disability Determination ☐ Other: _____

Dates of Service Requested: _____

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Discharge Summary	☐ Physician Orders	☐ Psychological Evaluation	☐ HIV/AIDS Test Results/Records
☐ Continuity/Transition of Care Packet	☐ Physician Progress Notes	☐ History and Physical	☐ Other: _____
☐ Aftercare Providers	☐ Social Service Notes	☐ Consultation Reports	_____
☐ Integrated Assessments:	☐ Nursing/BHT Notes	☐ Education Notes/School Assignments	
(A&R, Nursing, Social Service)	☐ Treatment Plans	☐ Medication Records	
☐ Psychiatric Evaluation	☐ Lab/Diagnostic Reports	☐ Consent Forms/Legal Paperwork	

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____ _____
Patient's signature (required for ages 12 and older) Date Signed Patient Witness Signature/Credentials Date Signed

_____ _____ _____ _____
Parent/Legal Guardian signature (if applicable) Date Signed Parent/Legal Guardian Witness Signature/Credentials Date Signed

_____ ☐ Verbal Consent Obtained from: _____ _____
Relationship to Patient Relationship to Patient

Signature of Staff: _____ Date: _____

This authorization is intended to allow Streamwood Behavioral Healthcare System to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to rediscloure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____ _____
Revocation Signature Date Time