

Streamwood Behavioral Healthcare System
1400 East Irving Park Road, Streamwood, IL 60107
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 Verbal Exchange and Documentation

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 **including** all records that include any substance use disorder and/or substance use disorder treatment records, or
- I authorize the release of the following information **excluding** 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"):

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

This authorization will expire on ___/___/20___. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

_____ Patient's signature (required for ages 12 and older)	_____ Date Signed	
_____ Parent/Legal Guardian signature (if applicable)	_____ Date Signed	_____ Relationship to Patient

Verbal Consent Obtained from: _____ 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 redisclosure 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.