Centegra HealthSystem

## BEHAVIORAL HEALTH AUTHORIZATION
## TO DISCLOSE AND/OR OBTAIN HEALTH INFORMATION

PATIENT NAME: ______________________________ MRN: ____________
LAST FIRST MIDDLE INITIAL

Patient Adress: ____________________________________________
Street City State ZIP

DATE OF BIRTH: ____________ TELEPHONE: ____________
MM/DD/YYYY

The undersigned here by authorizes and requests:

| | | |
|---|---|---|
| ☐ Outpatient Behavioral Health<br>☐ Inpatient Behavioral Health<br>☐ McHenry County Crisis<br>☐ Centegra Physician Care - Behavioral Health Services Only<br>☐ Other ____________<br>*Please use the separate Authorization for Release of Information Form when requesting records from Centegra Hospital - McHenry, Centegra Hospital - Woodstock Centegra Hospital - Huntley, or Centegra Primary care. | to disclose and provide the requested information to: | ____________<br>Individual/facility/Entity to be released to:<br>____________<br>Street Address:<br>____________<br>City State ZIP<br>____________<br>Telephone Number |

**Health Information To Be Disclosed:**

Date(s) of Treatment: ____________________

- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Psychosocial Evaluation
- ☐ Crisis Records
- ☐ Consult/Assessment
- ☐ Treatment/Discharge Plan
- ☐ Treatment Goals & Progress
- ☐ Emergent Conditions Only
- ☐ Dates of Admission & Discharge
- ☐ Drug/Alcohol Screening Results
- ☐ Attendance Records
- ☐ Entire Behavioral Health Record
- ☐ Medication Information
- ☐ Psychiatric Diagnosis
- ☐ Substance Abuse Evaluation
- ☐ Other (specify): ________

**Purpose For Disclosure:** ☐Further Care ☐Insurance Claim ☐Legal ☐ Other ____________

I fully understand and acknowledge that my medical record may contain information relating to mental health, developmental disabilities, alcohol/drug abuse and/or Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) test results or other sensitive information, and I expressly authorize the release of any such information contained in records designated above. I understand that re-disclosure of the information disclosed pursuant to this authorization is prohibited unless the person who consented to the disclosure specifically consents to the re-disclosure. However, once the information is disclosed, there is potential that it may be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws and regulations. Centegra Health System is not responsible for any re-disclosures of health information or medical records. I understand that records and communications shall remain confidential after the death of the patient and shall not be disclosed unless the patient's representative and therapist consent or disclosure is authorized by court order.

As described in Centegra's Notice of Privacy Practices, I understand and acknowledge that for the purposes of third party payment to Centegra Health System that diagnostic and therapeutic information may be required to process payment and will be disclosed to my insurance company and/or the insurance company's review agency and no authorization is required for such disclosure unless I choose to pay for services in full and out-of-pocket at the time such services are rendered. I understand that this authorization is voluntary and Centegra Health System will not condition treatment, payment, enrollment or eligibility for benefits on this authorization.

I may inspect and arrange for photocopies of records/health care information that are to be disclosed. I understand that I may be responsible for costs associated with obtaining copies of my records. I may revoke this authorization at any time, except to the extent that action has been taken in good faith reliance on this authorization, by submitting a written revocation to Centegra Health System Medical Records, 527 W. South Street, Woodstock, IL 60098.

**Unless otherwise revoked, this authorization will expire within one (1) year from the date of signature on ________ (include date) or ☐ other event ________.**

PATIENT/REPRESENTATIVE SIGNATURE: ______________________ Date:

If a personal representative is signing this authorization, please attach document(s) of the personal representatives's authority to action behalf of the patient, if required. * Patient 12 - 17 must sign authorization.

WITNESS SIGNATURE: ______________________ Date: ________

**White-Chart** **Yellow- Patient**

rev 4/16

*1AUTH*