TrilliumPlace
An affiliate of CarleHealth

AUTHORIZATION FOR RELEASE OF INFORMATION

Tazwood Mental Health Center, Inc., a subsidiary of Carle Health and Trillium Place
(Site Contact on Reverse)

Patient Name:_____ **DOB:**_____ **Patient ID#:**_____

I,_____, hereby authorize the mutual sharing of my highly confidential information between **Tazwood Mental Health Center, Inc.** and the following individual agency or individual:

Name of Agency or Individual: _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Fax Number:**_____

TYPES OF INFORMATION TO BE RELEASED (client/guardian must initial information to be shared)

Client	Guardian	Type of Information	Date Range of Information to Release
		Medical/ Primary Care (including a list of all medications, the last two visit notes, and lab results)	
		Psychiatric/Psychological (including diagnosis, assessment, treatment plans, current and/or past treatment progress, medication history, and treatment recommendations)	
		Alcohol/Drug (including diagnosis, assessment, treatment plans, current and/or past treatment progress, medication history, and treatment recommendations, program completion/discharge)	
		Inpatient Psychiatric records (including the initial psychiatric evaluation, discharge psychiatric evaluation, physical assessment, urinalysis toxicology screening results, and lab results)	
		HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)	
		Child Welfare (including incidents involving DCFS involvement, comprehensive assessments, service plans and progress towards plans, placement history, court reports, toxicology screening results, recommendations)	
		Legal (including arrests, convictions, probation history, progress while on probation/parole, detention history, toxicology screening results, recommendations)	
		Other (specify):	

PURPOSE FOR RELEASE OF INFORMATION (client/guardian must initial information to be shared)

Client	Guardian	Purpose for Release of Information
		Transfer of Care
		Coordination of Care or Consultation with above agency or individual
		Insurance Qualification
		Other (specify):

METHOD BY WHICH INFORMATION WILL BE RELEASED:

☐ Verbal ☐ Written ☐ Photocopy/Written ☐ Fax ☐ Audio ☐ Other: _____

I understand this authorization will expire one year from the date signed unless otherwise specified:_____.

I understand that I may revoke this authorization by notifying Tazwood Mental Health Center, Inc. in writing. I understand that, upon case closure, any active authorizations will remain in effect unless I revoke them in writing, up until their term of expiration. However, I understand that if I revoke this authorization, it will not have any impact on actions taken by Tazwood prior to notice of revocation.

I understand that I may refuse to sign this Authorization but it will not affect the commencement, continuation or quality of my Tazwood treatment. However I understand that my refusal to sign will result in the inability to share information.

I understand that I may inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my information. By my signature, I hereby, knowingly and voluntarily authorize Tazwood to use or disclose my information in the manner described above.

_____ _____ _____ _____
Signature of Patient (If over age 11) Date Signature of Witness Date

_____ _____ _____ _____
Parent/Legal Guardian Signature Date Signature of Witness Date

NOTICE TO RECEIVING AGENCY/PERSON: Prohibition of Redisclosure: Under the provisions of the Illinois Mental Health and Development Act and/or under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse clients records, records of HTLV-11 or HIV testing (AIDS) results, and AIDS treatment records – no such records, nor information from such records may be further disclosed without specific authorization for such redisclosure. A facsimile or photocopy of the original content of release of information is acceptable with telephone confirmation by the sender. The information that is not protected under the Illinois Medical Health Act and another state laws my be subject to redisclosure by the recipient and no longer be protected.

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Tazwood Mental Health Center, Inc.
Site Contact Information

☐ Pekin Office
3248 Vandever Avenue
Suite A, Pekin, Illinois
61554
Ph: 309-347-5522
Fax: 309-347-7302

☐ East Peoria/Eureka Office
111 W. Washington St,
Ste 230
East Peoria, Illinois 61611
Ph: 309-694-6462
Fax: 309-694-7812

☐ Lincoln Office
1231 Keokuk St., Lincoln,
Illinois 62656
Ph: 217-732-6865
Fax: 217-732-7845

☐ Residential Program:
1423 Valle Vista Blvd.
Pekin, Illinois 61554
Ph: 309-347-5606
Fax: 309-347-1298

OFFICE USE ONLY

Information Released	Document Creation Date	Date Released	Staff Initials
Comprehensive Assessment(s):			
Treatment Plans (s):			
Psychiatric Evaluations/Reviews			
Medication Profile(s):			
Progress Note(s):			
Continued Stay Review(s):			
Discharge Summary(s):			
Billing Information:			
Other (specify):			