Release of Information BHU

CarleHealth
Proctor Hospital

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient's Name:_____
Last First Middle

Home Address:_____

Telephone (Home): _____ Telephone (Mobile): _____

E-mail Address: _____ Date of Birth: _____

I, _____, authorize: Addiction Recovery Center at Carle Health Proctor Hospital, 5409 N. Knoxville Avenue, Peoria, IL 61614, to disclose the following highly confidential protected health information:

A. From: Addiction Recovery Center at Carle Health Proctor Hospital
   To: (physical address for paper copies; email address for digital copies): _____
B. To: Addiction Recovery Center at Carle Health Proctor Hospital, 5409 N. Knoxville Avenue, Peoria, IL 61614
   From: _____

CONTENT TO BE DISCLOSED: Please put your initials (preferred) or check mark by each requested item:
Date(s) of Service requested (from when to when): _____

___ Complete Medical File
___ Discharge & Summary
___ History & Physical
___ Consultation
___ Procedure Reports
___ ED Record
___ Assessment Results/Recommendations
___ Treatment Verification for Sec. of State
___ Lab Reports
___ Cardiology Reports
___ X-ray Reports
___ X-ray Films
___ Disclosure of Highly Confidential Information
___ Mental Illness / Developmental Disability
___ Child Abuse & Neglect ___ Venereal Disease
___ Substance Addiction/Use (i.e., Alcohol/Drug)
___ Abuse of an Adult with a Disability
___ Sexual Assault
___ HIV / AIDS Testing / Treatment
___ Other _____

PURPOSE: The protected health information is being used or disclosed for the following purpose(s):

___ Continuation of Care ___ Payment and Healthcare Operations ___ Other: (Specify): _____

I understand that the information used or disclosed *(excluding information subject to the notice at the bottom of this authorization*)* may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.	**I understand** that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Proctor's treatment of me.
I understand that Proctor may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.	**I understand** that I may inspect or copy the protected health information to be used or disclosed as permitted under federal or state law.
Canceling this authorization: I may cancel this authorization at any time by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to Carle Health Information Management located at 611 W. Park St., Urbana, IL 61801. The cancellation will take effect when Carle Health receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Carle Health received my letter.	**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 health information. By my signature, I hereby, knowingly and voluntarily authorize Proctor to use or disclose my health information in the manner described above.

TERM: If not revoked, this authorization will expire on _____(specify date). Date of expiration not to exceed one (1) year.

By signing below, I hereby, knowingly, and voluntarily authorize Carle Health Proctor to use or disclose my protected health information in the manner described above.

_____ _____ _____ _____
Signature of Patient** Date/Time Signature of Witness** Date/Time

_____ _____ _____ _____ _____
Signature of Parent/Legal Guardian Relationship to Parent Date/Time Signature of Witness*** Date/Time

***NOTICE TO RECEIVING AGENCY / PERSON:** Prohibition of Re-disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2 and other laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 2.31.) The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 2.12(c)(5) and 2.65. Under the provisions of the federal confidentiality rules (42 CFR part 2); the Illinois Mental Health and Developmental Disabilities Confidentiality Act; the Illinois Genetic Information and Privacy Act; the Illinois AIDS Confidentiality Act; the Illinois Alcoholism and other Drug Abuse and Dependency Act; and other laws, the confidentiality of mental health records, records containing genetic information, substance use treatment, HIV/AIDS testing/treatment, and certain other records and information may not be further disclosed without the patient's specific authorization for such re-disclosure. **Minors 12 years of age or older shall sign for release of records pertaining to STD's, substance use, mental health and developmental disabilities. See relevant internal policies for additional information.
***Witness' Signature required for release of information about a mental illness or developmental disability

NOTICE: Patients may be charged a reasonable fee for a copy of their protected health information.

PATIENT STICKER:

Instructions for Health Information Management (HIM) (*internal use – check if records are requested*)

☐ Records request