CarleHealth
Proctor Hospital

PATIENT AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH RECORDS - PROCTOR

Patient's Name: _____

Last *First* *Middle*

Home Address: _____

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

Email Address: _____ **Date of Birth:** _____

I,_____, authorize: **Carle HEALTH Proctor BEHAVIORAL HEALTH SERVICES,**
5409 Knoxville Ave, Peoria IL 61614 to disclose the following highly confidential protected health information:

A. **From: Carle Health Proctor Behavioral Health Services**
To: *(physical address for paper copies; email address for digital copies)*: _____

B. To: Carle Health Proctor Behavioral Health Services
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): _____

___Intake Data	___Discharge Instructions	___Academic History & Current Course Work
___Developmental & Psychosocial History	___Psychological Reports/Evaluations	___Achievement & Aptitude Test Results
___Psychiatric History/Evaluation	___Immunization Records	___Educational Services Summary (including Academic & Behavioral Reports)
___Substance Use History	___Legal Documents	___Court Services Reports
___Other Addiction History_____	___Medical History/Examination/Test Results	___Treatment Plan
___Speech & Language Reports/Evaluations	___Medications	___Progress Notes
___Emergency Department Records from (specify date of visit):_____	___Occupational Therapy Reports	___Other:_____
	___Individual Education Plan	
___Treatment/Discharge Summary/Discharge Progress Notes		

PURPOSE: The highly confidential protected health information is being used or disclosed for the following purpose(s):
___Transfer of Care ___Consultation with Physician ___Case Coordination ___Treatment Planning
___Legal Consultation ___Insurance Qualification ___Payment & Health Care Operations:_____Other:

I understand if I refuse to sign the consent to this release of information, the following are potential consequences (specify here, if any):

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.

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

Under 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. 42 CFR part 2 also prohibits unauthorized disclosure of these records. **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.

Revised 12/2024

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

☐ Records request