5230 S. 6th Street,
Springfield, Illinois 62703

Patient Name: ____________________
DOB: ____________________
MRN: ____________________
OR PLACE PATIENT STICKER HERE

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

I hereby authorize the Lincoln Prairie Behavioral Health Center to: ❐ **Disclose** ❐ **Obtain** ❐ **Disclose & Obtain**

Pt and/or Guardian Initials	Types of Information to be released (if not initialed, info will be excluded)	Pt and/or Guardian Initials	Types of Information to be released (if not initialed, info will be excluded)
	Medical: ☐ History and Physical Exam ☐ Labs ☐ Results of Past Medical Assessments ☐ Treatment ☐ Treatment Results ☐ Recommendations		**HIV and STD Testing or Treatment** (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such test were positive or negative)
	Psychiatric/Psychological: ☐ Psychiatric/Psychological Evaluation and Assessments ☐ Diagnosis ☐ Treatment Plans ☐ Medication Records ☐ Progress Notes ☐ Discharge Summary ☐ Discharge Safety Plan		**Alcohol/Drug:** ☐ Diagnosis ☐ Assessments ☐ Treatment plans ☐ Current and/or Past Treatment Progress ☐ Medication History ☐ Recommendations
	Education: ☐ Educational testing ☐ Current Grades ☐ Progress Reports ☐ IEP Information (within 5 years) ☐ Educational Aftercare Plan (pg 3) ☐ Attendance Records ☐ Therapy Notes ☐ Assignments/Homework ☐ Invitation to Weekly Staffing		**Other/or Exclude These Items (Circle):**

For the Following Dates of Service:____________________

For the purpose of: ❐ Coordinating Services ❐ Transfer of Treatment ❐ At the request of the individual

This Disclosure is being made to/from:

Name of Person/Agency:	
Address:	
Phone #:	**Fax #:**

Method of Release: ❐ Verbally ❐ Fax ❐ Photocopy/Written ❐ Electronic ❐ Other: __________

Pt and/or Guardian Initials	**Check to Confirm Understanding**
	I understand that a copy or fax of this consent will be considered legal in lieu of the original document.
	I understand that the above-named person/agency authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the person/agency receiving this information is not a healthcare provider/plan covered by HIPAA regulations, the information described may be re-disclosed and no longer protected by HIPAA regulations.
	I understand that my refusal to consent to the release of the above-mentioned information will prevent disclosure of the information.
	I understand this consent is valid for one (1) year following the date of this authorization, and I may revoke it in writing at any time except to the extent that action has already been taken.
	I understand payment may be required when requesting copies of LPBHC records as allowed by Illinois law; a records clerk may contact me to advise of copy fee and estimated date of completion.

____________________ ____________
Patient's Signature (12 years of age and older) Date/Time

____________________ ____________
Legal Guardian's Signature Date/Time

____________________ ____________
Witness Signature Date/Time

❐ Verbal Consent:____________________
(Name of Person Giving Verbal Consent)

____________________ ____________
2nd Witness Signature (Required for Verbal Consent) Date/Time

Return this form to:
Health Info Management Dept.
Lincoln Prairie Behavioral Health Center
5230 S. 6th Street
Springfield, IL 62703
(217) 585-1180 phone
(217) 585-5665 Primary fax
(217) 585-4746 Secondary fax

5230 S. 6th Street,
Springfield, Illinois 62703

Patient Name: ______________________
DOB: ______________________________
MRN: ______________________________
OR PLACE PATIENT STICKER HERE

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

I understand that once the releasing entity discloses my health information to the recipient, the releasing entity cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information. I understand that the releasing entity may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that the releasing entity may deny this request under limited circumstances as provided for under federal and Illinois law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the releasing entity who did not participate in the releasing entity decision to deny my request.

I understand that I may at any time make a written request to the releasing entity to inspect and/or obtain a copy of my health information, and that the releasing entity will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complain regarding the denial.

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 my treatment at Lincoln Prairie Behavioral Health Center; except, however, if my treatment at Lincoln Prairie Behavior Health Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Lincoln Prairie Behavioral Health Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the releasing entity's Health Information Management Department. The revocation will be effective immediately upon the releasing entity's receipt of my written notice, except that the revocation will not have any effect on any action taken by the releasing entity in reliance on this Authorization before it received my written notice of revocation.

I understand that treatment, payment, enrollment, or eligibility for benefits cannot be denied to me due to my refusal to sign this authorization.

I may contact Lincoln Prairie Behavioral Health Center's Health Information Management Department at (217) 585-1180, or by mail at 5230 South Sixth Street, Springfield, Illinois 62703.