

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

230 S. 6 <sup>th</sup> Street,		OD DI ACE DATIENT STICKED HEDE			
Springfield, Illinois 62703			OR PLACE PATIENT STICKER HERE		
	TION TO DISCLOSE/OBTAIN HEALTH INFORMATIO		<b>-</b>		
	norize the Lincoln Prairie Behavioral Health Cente		☐ Disclose	Obtain Disclose & Obt	
et and/or Guardian Initials	Types of Information to be released (if not initialed, info will be excluded)	Pt and/or Guardian Initials	/1	of Information to be released nitialed, info will be excluded)	
	<b>Medical:</b> □ History and Physical Exam			<b>ng or Treatment</b> (including the fact that dered, performed or reported,	
	□ Labs □ Results of Past Medical Assessments □ Treatment		regardless of whet positive or negativ	ther the results of such test were (e)	
	☐ Treatment Results ☐ Recommendations				
	Psychiatric/Psychological:		Alcohol/Drug:  ☐ Diagnosis		
	☐ Psychiatric/Psychological Evaluation and Assessments ☐ Diagnosis		☐ Assessments		
	☐ Treatment Plans		☐ Treatment plans		
	☐ Medication Records ☐ Progress Notes		☐ Medication Histor	ist Treatment Progress	
-	□ Discharge Summary □ Discharge Safety Plan		Recommendation		
	Education:  Guardian Educational testing Current Grades Progress Reports Guardian EP Information (within 5 years)  Attendance Records Therapy Notes Assignments/Homework Invitation to Weekly Staffing		Other/or Exclude	cclude These Items (Circle):	
	□ Educational Aftercare Plan (pg 3)				
	owing Dates of Service:				
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Date/Time

2<sup>nd</sup> Witness Signature (Required for Verbal Consent)



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.