HIPAA Release Form Illinois

Authorization to disclose/obtain information:		
(1) I, ________________________________ authorize ________________________________ to:		
disclose	obtain	disclose and obtain
(2) *(Please check all that apply):*		
Discharge summary	Record abstract	Lab/X-ray
Social history	Discharge staffing	Patient review
Physician's orders	History and physical	Psychiatric evaluation
Med. administration records	Behavioral plans	Treatment/hab plan
Consultations	Progress notes	Photos
Assessments *(specify type):*		
Other *(specify):*		

Concerning the care of the below-named person from DATE (or RANGE OF DATES):	
(3)	
About (name):	Date of birth:
Social security no.:	Alias:

(4) For purposes of *(check all that apply):*		
Personal use	Continuity of care	Placement transfer
Financial/benefits	Attorney	State law/court
Death	Other *(specify):*	

(5) Information may be disclosed/obtained via:	
Mail	E-mail
In person	Fax (for urgent/emergency needs)
Restrictions, if any:	
(6) Disclose to:	**Obtain from:**
Name:	Name:
Address:	Address:
City/state/zip:	City/state/zip:
(7) This authorization is valid until the calendar date:	

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, or HIV/AIDs.

CHECK BELOW FOR EXCLUSIONS ONLY.

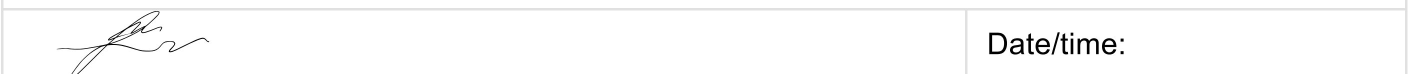
Alcohol/substance abuse	Mental health	Developmental disabilities
HIV/AIDs	Other *(specify):*	

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and sent/given to the facility's record department. I understand that no revocation of this authorization shall be effective to prevent the disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

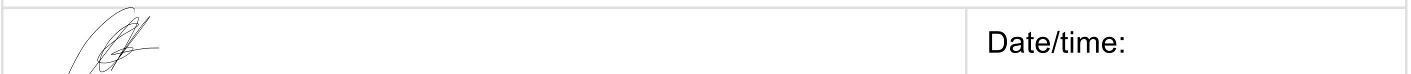
(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

(12) Signature of individual (age 12 or older):



Date/time:

(13) Signature of parent/guardian (under 18 or disabled):

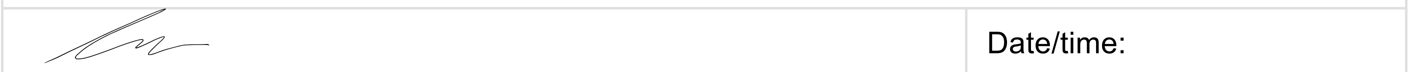


Date/time:

(14) Witness OR (2nd parent/guardian, if co-custodial, may sign here):

Date/time:

(15) Signature of staff person disclosing/obtaining information:



Date/time:

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System. A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally Identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re-disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1.

A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits.