OSF HEALTHCARE

AUTHORIZATION TO USE OR DISCLOSE SUBSTANCE ABUSE COUSELING NOTES

MUST COMPLETE ALL BLANK LINES

PATIENT INFORMATION	Patient Name:_____ Address:_____ City, State, Zip Code:_____ Phone Number: _(_____)_____ Date of Birth: _____
PROVIDER/ORGANIZATION: (Who is authorized to release your information)	**I hereby authorize:** OSF Healthcare SFMC Medication Assisted Recovery Clinic, 617 NE Glendale, Peoria, IL 61603
REQUESTOR: (To whom you want your information to go)	**To Release my medical records to:** Name: _____ Address: _____City, State, Zip Code:_____ Phone Number: _(_____)_____
Disclose Records to	☐ OSF MyChart ☐ CD (mailed to address above) ☐Paper (mailed to address above) ☐ Encrypted Email _____
PURPOSE	☐ Continuing Care ☐ Insurance ☐Legal ☐ Personal ☐Other _____
INFORMATION TO BE DISCLOSED:	☐ Substance Abuse Counseling Notes

HIGHLY CONFIDENTIAL INFORMATION

It is my full understanding that the records and communications to be disclosed WILL include all Highly confidential information such as alcohol and substance abuse, mental health, developmental disabilities, HIV/AIDS, and genetic testing and information derived from genetic testing information.

If you want to have any of this information excluded, check below.

☐ **Alcohol/Substance Abuse** ☐ **Mental Health** ☐**Developmental Disabilities** ☐**HIV/AIDS** ☐**Genetic Testing and information derived from genetic testing** ☐ **Other:** _____

_____

SUBSTANCE ABUSE INFORMATION

I understand my **substance abuse** information will be released under this authorization.

- *Substance Abuse information is protected by federal law. I understand my information may be re-disclosed pursuant to 42 CFR Part 2 and the HIPAA privacy rule.*

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By signing below,

- I have reviewed all the information on page one and filled it out completely.
- I understand that this authorization is voluntary, and I can refuse to sign this authorization. I understand that person(s) or organization(s) may NOT condition my treatment, payment or enrollment based on my signature on this authorization.
- I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and once the information is re-disclosed it **may not be protected** by the HIPAA privacy rule.
- I understand I have **the right to revoke** this authorization at any time. If I revoke this authorization I must do so in writing to the Health Information Department of the OSF Healthcare Facility listed above under Provider/Organization. I understand that the revocation will not apply to information that has already been disclosed in response to this release.
- I understand I have the right to inspect the information to be disclosed.
- I understand this authorization will **expire 1 year from the date of the signature** below or **upon a date, event or condition that I am specifying here:** _____

_____ _____

Signature of Patient or Patient Representative ***Date***

_____ _____

Signature of Child (12-17) for MHDDCA purposes only ***Date***
405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act

_____

Signed by Patient Representative, print name, state relationship to Patient and provide evidence of Authority to act for individual

_____ _____ _____

Signature of witness who can verify patient identity ***Relationship to Patient*** ***Date***
(Must be signed for Substance Abuse information to be released)