



**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
SUBSTANCE ABUSE RECORDS
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	<input type="checkbox"/> OSF MyChart <input type="checkbox"/> CD (mailed to address above) <input type="checkbox"/> Paper (mailed to address above) <input type="checkbox"/> Encrypted Email _____
PURPOSE	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other _____
INFORMATION TO BE DISCLOSED:	<input type="checkbox"/> Abstract <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Results <input type="checkbox"/> Imaging Films <input type="checkbox"/> Medical Bills <input type="checkbox"/> Other (please be specific): _____ Date(s) of Visit: _____
<u>HIGHLY CONFIDENTIAL INFORMATION</u> <i>It is my full understanding that the records and communications to be disclosed MAY include Highly confidential information such as HIV/AIDS, sexually transmitted disease, genetic testing, mental health information, and reproductive health information. If you want to have any of this information excluded, check below.</i>	
<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> STD <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental Disability Information <input type="checkbox"/> Reproductive Health <input type="checkbox"/> Other: _____	
<u>SUBSTANCE ABUSE INFORMATION</u> I understand my substance abuse information will be released under this authorization. <ul style="list-style-type: none">• 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 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
405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act*

Date

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

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

Relationship to Patient

Date