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 Alton - Saint Anthony's Health Center, #1 Saint Anthony's Way, Alton, IL 62002
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 MAY include Highly confidential information such as HIV/AIDS, drug and alcohol abuse, sexually transmitted disease, genetic testing, and mental health information. If you want to have any of this information excluded, check below.

☐ **HIV/AIDS** ☐**STD** ☐**Genetic Testing** ☐**Mental Health** ☐**Developmental Disability Information**
☐ **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)