Riveredge Hospital
8311 West Roosevelt Road
Forest Park, IL 60130
708-771-7000

Authorization to Use or Disclose Protected Health Information

(Patient Name) _____ (Date of Birth) _____ (SS#) _____ (Date(s) of Treatment) _____

I hereby freely and voluntarily authorize Riveredge Hospital to. . . .

____ Release/disclose my protected health information to:
____ Obtain my protected health information from:

(Individual, Facility, or Organization) _____ (Phone Number) _____

(Address) _____ (Fax Number) _____

(City, State, Zip Code) _____

The purpose of this disclosure is for:

__ insurance purposes __ educational placement __ legal reasons __ medical treatment
__ discharge planning __ continued treatment __ the patient __ progress updates
__ other (explain) _____

☐ Psychiatric ☐ Substance Abuse ☐ Medical information to be used or disclosed:

__ Discharge summary __ Psychiatric Evaluation __ History & Physical __ Psychological testing
__ Treatment Plan(s) __ Lab/X-ray results __ Psychosocial assessment __ Physician's Orders
__ Aftercare Plan Other (explain) _____

The consequences of my refusal to consent, if any, are _____

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal and state law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Riveredge Hospital Privacy Officer, except to the extent that action has already been taken in reliance on it. **This authorization will expire 180 days ( ) following discharge, or ( ) following signature** unless another date or condition is specified. Other date or condition specified: _____.

Signatures:

_____ _____
(Signature of patient if at least 12 years old) *(Date)*

_____ _____ _____
(Guardian or Representative) *(Date)* *(Relationship to Patient)*

_____ _____
(Witness) *(Date)*

***Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Notice to receiving agency/person: Under the provision of 405 ILCS 5 II. Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure consents to such redisclosure.**

FOR HOSPITAL USE ONLY: ***MR #*** _____ ***Date Info. Released*** _____ ***Initials:*** _____