Hartgrove Behavioral Health System
Authorization to Release and Disclose Patient Information

1. ____ (D.O.B.) ____/____/____
(Name of Patient) Please include/list aliases or maiden name

2. ____ (   ) ____________________
(Name of Patient or Parent/Legal Guardian) Telephone number

____
(Street address) (City, state, zip code) Email:

3. I authorize **Hartgrove Behavioral Health System** to disclose to

Name ______________________________ Phone Number (   )

Address ______________________________ City, State, Zip Code

Fax Number (   ) ______________________________ Email:

4. FOR THE PURPOSE OF OR NEED FOR DISCLOSURE: (Check √ applicable categories)

☐ Personal ☐ Further medical care ☐ Legal investigation ☐ Continuum of care ☐ Disability determination

☐ Academic ☐ Other ____

5. IDENTIFY: Date range: ________________________________ If no dates specified, last encounter will be used

6. *Check {✓} information to be released: If not checked a **standard abstract** will be released.*

√		√	
	Discharge Summary		**Neurological Evaluation**
	Medication DC Summary		**Trauma Evaluation**
	Psychiatric Assessment		**Lab/Diagnostic Reports**
	History and Physical		**Physician Orders**
	Psychosocial Assessment		**Psychological Evaluation**
	Information containing Alcohol/Drug Abuse		**Records of HIV/AIDS testing results and AIDS treatment records**
	Aftercare Discharge Plan		**Other:**

Once the requested PHI is disclosed, the PHI's recipient may redisclose it, therefore the Privacy Regulations may no longer protect it. This authorization is also intended to allow Hartgrove Behavioral Health System or its recipient to freely exchange information verbally and reciprocally for the specific life of the release, in the best interest of the patient. I understand my right to revoke this authorization at any time, in writing and must be sent/given to Hartgrove Behavioral Health System facility record's department. I understand that failure to sign this authorization may hinder the above-indicated purpose being achieved. I understand my right to inspect and copy the information to be disclosed. The information disclosed will not be used for any purpose other than that indicated above.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol & Drug Abuse Patient Records and the Illinois Confidentiality Act, no such records, nor information from such records may be further disclosed without specific authorization for such redisclosure.

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

Exclusions, if any: ____.

7. This Authorization expires on: ______/______/______ If I do not indicate a date, this will expire one (1) year from the date of my signature below.

8. Signature of Patient (Age 12 and above) ________________________________ Date_________ or ☐ Declined.

9. **Parent/Guardian:** By my signature herein, I certify that I am a custodial parent or guardian of the minor patient and that I have full legal authority to consent to the disclosure of confidential information indicated above. It is my intention that a photocopy or facsimile of this authorization shall have the same legal force and effect as the original copy.

________________________________ ____________________ Date______________________
Signature of Parent/Legal Guardian **Relationship to Patient**

10. **Witness/Title:** ____ Date______________________

This Authorization must be filled out in its entirety or it will not be valid. Verbal consent is not valid.
Electronic signature not acceptable only wet signature.

INSTRUCTIONS: AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

1. Complete the patient's name and date of birth and aliases or a maiden name to help correctly identify the individual.

2. Completed by the parent/guardian/person requesting record(s) person's name, address, and phone number.

3. Complete the name and address of the agency, facility or person to whom Hartgrove Behavioral Health System will disclose the information to. If you wish it to be faxed, include area code and number.

4. Check the purpose or reason why the information needs to disclose.

5. Identify and check appropriate box:
   Provide date range __________ or if no dates specified, last encounter will be used.

6. Check the specific information you wish to disclose. If not checked a standard abstract will be released. Check only, what is the minimum necessary to fulfill the purpose of disclosure. Staff only - Staff initials by specific information disclosed.

7. Complete the calendar date (month, day and year) on which the authorization will expire. If not indicated, authorization to disclose protected information will expire one (1) year from the date of the signed signature.

8. Patient to sign full name and date here – age 12 and above (electronic signature not acceptable, only wet signature).

9. Parent to sign full name (electronic signature not acceptable, only wet signature) and date here if -
   - Patient is less than 12 years of age or
   - If patient is between 12 and 17 and has signed on line 8 or
   - If patient is 18 years of age or older but is legally disabled. You must provide a *copy of the Guardianship court order granting you this right.*

   Guardian to sign here
   - If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. You must provide a copy of the court order granting you this right.

10. Witness/Title to sign and date here. All authorizations require a witness signature to attest to the identity of the person entitled to give consent (person signing line 8/9) Witness line may be used by 2nd parent/guardian.

Mailing address: **Hartgrove Behavioral Health System Attn: Medical Records**
5730 W. Roosevelt Road
Chicago, Illinois 60644

Direct: 773.413.1778
Fax: 773-413-1775
Email: HartgroveMedRecROI@uhsinc.com