

## Hartgrove Behavioral Health System Authorization to Disclose/Obtain Protected Health Information

1. \_\_\_\_\_ (D.O.B.) \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Name of Patient) Please include/list aliases or maiden name
2. I \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Name of Patient or Parent/Legal Guardian) Telephone number
- \_\_\_\_\_  
(Street address) (City, state, zip code)

3. I authorize **Schoolhouse Counseling Center (specify school district location / address below):**  
\_\_\_\_\_ to **disclose to**  
\_\_\_\_\_  
Name
- \_\_\_\_\_  
Address City, State, Zip Code
- \_\_\_\_\_  
Phone Number ( ) Fax Number ( ) Email:

I authorize \_\_\_\_\_ to release the following information to:

**Schoolhouse Counseling Center (specific school district location / address below):**

\_\_\_\_\_  
Name Address City/State/Zip Code

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.

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>															
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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/Minor (12-17) \_\_\_\_\_ 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.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Relationship to Patient Date \_\_\_\_\_

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  
DISCLOSE/OBTAIN  
PROTECTED HEALTH 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 or complete the name of the agency, facility or person whom the information is being obtained from. If you wish it to be faxed, include area code and number.
4. Check the purpose or reason why the information needs to be disclosed/obtained.
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/obtain. 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 or obtain protected information will expire one (1) year from the date of the signed signature.
8. Patient to sign full name and date here if – age 12 or older.
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
  - 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 2<sup>nd</sup> parent/guardian.

Mailing address: **Schoolhouse Counseling Center**  
**Attn: Medical Records**  
Direct: 773-365-1012 Fax: 708-628-3358  
Email: [HartgroveSchoolhouseCounseling@uhsinc.com](mailto:HartgroveSchoolhouseCounseling@uhsinc.com)