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Consent Form for Release of Confidential Information by Centerstone

I, _____ , whose date of birth is _____ /_____ /_____ , and whose Social Security Number is _____ authorize Centerstone to disclose to staff and contractors of the Illinois Department of Human Services (IDHS), Division of Alcoholism and Substance Abuse (DASA), and Division of Mental Health (DMH) client treatment information/records which are necessary to file claims for reimbursement, and for the discharge of the legal or contractual obligations of the third party payer or funding source.

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may in writing revoke this consent at any time, except to the extent that disclosure was made prior to the time 1 revoked it I further understand that disclosure includes my right to inspect and copy (at my own expense) the information to be disclosed.

This is a continuing disclosure which covers the entire treatment episode and until all claims are filed and processed.

The Department of Human Services (OHS) may pay for some or all of the costs of your community mental health services. If OHS is to pay for these services, the provider must report certain personal information to the Department If you do not want the provider to report this information, you may decline to be a recipient of OHS funding. If you do not decline, the provider will report all of the following information to the Department of Human Services:

- Full Name
- Social Security Number
- Birth Date
- Gender
- County of residence
- Household income & size
- Services rendered

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It has been explained to me that if I refuse to consent to this release of information, the following consequences are: I will not be eligible for any type of financial assistance and must pay the full rate prior to each service episode. _____ Client Initials

Executed this _____ day of _____, 20_____

_____ Signature of Patient

_____ Signature of Parent, Guardian, or Authorized Representative (when required)

_____ Witness

Notice to receiving Agency/Person: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. A general authorization for release of medical or other information is NOT sufficient for this purpose.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol & Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure. Disclosure of the Social Security Number is mandatory pursuant to 42 U.S.C. 405 (c) (2) and will be used to determine eligibility for service, determination of reimbursement by Medicaid, Identification, and detection and possible prosecution for fraud.