CENTERSTONE

Client ID # _____

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

REQUESTED BY: [ ] Self [ ] Health Care Provider [ ] Family [ ] 3rd Party Attorney [ ] Client Attorney [ ] Other: _____

AUTHORIZATION IS GIVEN FOR CONFIDENTIAL INFORMATION DISCLOSURE AS INDICATED TO :

[ ] Release from Centerstone [ ] Release and request from and to Centerstone [ ] Release to Centerstone

Name _____

Address _____

Phone (____) _____ - _____ Fax (____) _____ - _____ E-Mail: _____

Client Name _____ Phone (____) _____ - _____

Address _____

Last 4 Digits SSN _____ Date of Birth ___ / ___ / _____

INFORMATION TO BE DISCLOSED:

[ ] Discharge Summary	[ ] Intake Assessments	[ ] Medication/Injection Log	[ ] Billing Information
[ ] Psychiatric Evaluation/Psychological Evaluation	[ ] Progress Notes	[ ] Laboratory Tests	[ ] Appointment History
[ ] Assessments (e.g. AIMS, CANS, ANSA, NOMS)	[ ] Monthly Report	[ ] Care Plan	[ ] Other:

Dates of Service for which records are requested: Begin: _____ End: _____

EXCLUDED INFORMATION:

[ ] Drug and Alcohol Records [ ] Infectious Disease Records [ ] Mental Health Records [ ] HIV/AIDS [ ] STD/STI

METHOD(S) OF DISCLOSURE: [ ] Verbal [ ] Printed [ ] Fax* [ ] Email* [ ] Thumb Drive

PURPOSE OF DISCLOSURE:

[ ] To Develop a Diagnosis, Treatment and Rehabilitation Plan	[ ] Legal Proceedings
[ ] To Coordinate Medical, Psychological, and Social Rehabilitative Process	[ ] At client's request
[ ] To Determine Eligibility or Process Insurance Claims for Services Provided	[ ] Other (describe): _____

I understand that my records are protected under state and federal confidentiality statutes and/or regulations, and that the information used or disclosed ***may*** be subject to re disclosure by the person(s) receiving it and no longer protected by the federal privacy regulations. I further understand that these records will not be disclosed by Centerstone without my written authorization unless otherwise allowed by state or federal statute, rule, or regulation. I understand the released information may include HIV/AIDS, STD/STI information. I authorize the use of a photocopied, faxed, or scanned presentation of this form as a valid original for the release or disclosure of the information described above. I further authorize Centerstone and its agents to utilize this authorization electronically. I understand that Centerstone is not responsible for any alterations made to Centerstone records that are released to any party. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Centerstone. I understand that I have a right to a copy of this authorization. I understand that I may revoke this authorization at any time in accordance with 45 CFR §164.508 and 42 CFR Part 2, except to the extent that Centerstone has already acted in reliance on this authorization. A revocation should be in writing and delivered to Health Information Department.

In the absence of such written revocation, this authorization will expire in 365 days unless otherwise noted **below:**

Authorization for records expires on: ___/___/_____ or _____(condition or event).

*****Sending your personal health information to an email address or by fax is not a secure delivery method and may expose your health information to others. By choosing this delivery method, you release Centerstone from any liability involving a potential or actual breach of your health information that has been delivered upon your request to an email address or by fax.

Signature: _____ Date: ___ / ___ / ___

(Client/Legal Guardian/Representative)

If signed by other than the client, please indicate legal relationship:_____

Witness

Signature: _____ Date: ___ / ___ / ___

Notice to Recipient of Client Records/Information:

Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without the further consent of the client/patient except as allowed by statute, rule, or regulation. The receiving organization/party will be solely responsible for any unauthorized disclosure or use. This authorization to disclose was developed to comply with the provisions regarding disclosures of medical and mental health records, alcohol and drug abuse records, and other information under: Centerstone Policies; 42 CFR Part 2; Illinois statutes, regulations, and case law; and HIPAA.