rosecrance

Authorization to Release Information

Client Name: _____ Client ID: _____ DOB: _____

I authorize Rosecrance Inc. and its Affiliates ("Rosecrance") to communicate with, release information to, and obtain records and information from:

Name:	Relationship:	Address:	Contact Information:

Purpose of Release:
The purpose of this disclosure of information is to share treatment information and to coordinate care. If other purpose, please specify: _____.
In the event of a disclosure necessary for emergency notification, Rosecrance will disclose that the client is participating in treatment.

Information to be Disclosed: ☐ **Complete Record**

- ☐ Medical/Psychiatric/Medication
- ☐ Lab Reports
- ☐ Assessments
- ☐ Progress Notes
- ☐ Treatment Plans/Treatment Plan Reviews
- ☐ Discharge Summaries
- ☐ Presence in treatment only
- ☐ Other _____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Rosecrance Medical Records Department. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
This authorization will expire on the following date: _____. If I do not specify an expiration date, this authorization will expire one year from the date of execution of this authorization.

Conditions
I further understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. Rosecrance will not condition my treatment on whether I give authorization for the requested disclosure. I also have a right to inspect and copy the information that is to be released.

Form of Disclosure
We reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, by facsimile, or electronically. Rosecrance does not use encryption technology for e-mail and therefore, information being transmitted via email may be viewed by unauthorized persons during transmission. I understand that it may be impossible to determine whether unauthorized access to e-mail has taken place. In addition, e-mail usage may be monitored by Rosecrance administration for internal security purposes.

Redisclosure
Federal and State law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

_____ _____ _____ _____
Signature of Client Date Signature of Parent, Guardian or Personal Representative Date

(Clients ages 12-17 years old are requested to sign and date with co-signature of parent/legal guardian) If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____
Witness Signature Date

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT, AND 45 CFR PARTS 160 & 164 (HIPAA)