Lake County Health Department
and Community Health Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

Rev. 3-11 (C)(H)

I, _____, DOB _____, authorize Lake County Health Department and
(Client's Name) (Date of Birth)

Community Health Center, Behavioral Health Services, _____
(Program) (Telephone)

_____
(Address) (City) (State) (Zip) (FAX)

to: ☐ Send ☐ Receive the following ☐ to ☐ from the following agency and/or person(s):

_____
(Agency Name and/or Person) (Telephone)

_____
(Address) (City) (State) (Zip) (FAX)

Specific nature of information to be released:

- ☐ Clinical Assessments
- ☐ PIP referral
- ☐ Discharge Summary/Continuing Care Plans
- ☐ History and Physical
- ☐ Laboratory/Waived Test Results
- ☐ Cooperation with treatment/attendance
- ☐ Medication Records
- ☐ Physician Notes
- ☐ Psychiatric Assessment
- ☐ Treatment Plan
- ☐ Treatment Progress Report
- ☐ Verify Presence
- ☐ Other _____

Specific Treatment Dates/Episodes: From _____ To _____

The above information will be used for the following purposes:

- ☐ Case Review
- ☐ Continuing treatment or program
- ☐ Coordination of services
- ☐ Determining eligibility for benefits or programs
- ☐ Family/Significant Other contact
- ☐ Evaluation/Planning appropriate treatment or program
- ☐ Other: _____

Consequences of refusal to consent, if any: _____

This authorization is valid until: _____
(Month/Date/Year NOT TO EXCEED ONE YEAR)

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

I understand that I may revoke this authorization at any time by providing written notice to LCHD/CHC.

☐ I withdraw/terminate this authorization, effective _____ Signature _____ Date: _____
(Effective Date) (Client signature)

I further understand that **released information may not be re-disclosed** to any other person or organization without my written consent. This is in compliance with the Federal Regulations Governing the Confidentiality of Alcohol and Drug Abuse patient records, as noted in 42 CFR, Part 2.32 (a), or in compliance with the Illinois Mental Health and Developmental Disabilities Act]. If I decide to approve redisclosure of information, I understand it will not be protected by the Privacy Rule.[

I further understand that I have a right to inspect and/or receive a copy of the medical information to be released and also receive a copy of this authorization.

I further understand I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.

CLIENT NAME: _____ MRN: _____