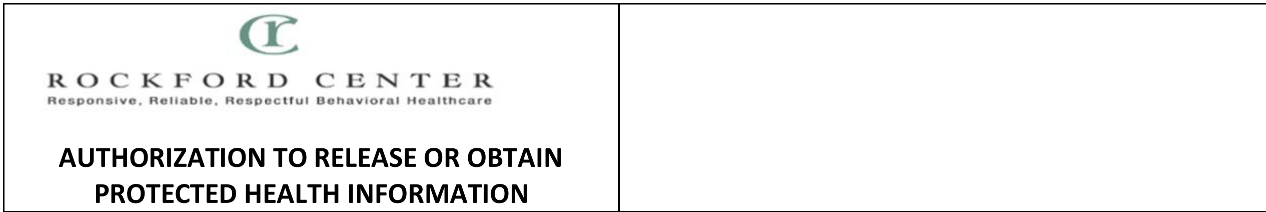

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Information:

Name	Date of Birth
Address	City/State/Zip
Phone #	Med Rec # *(hospital use only)*

I authorize the Rockford Center to ☐ obtain information from or ☐ release information to:

Name of Person or Organization	
Address	City/State/Zip
Phone #	Fax #

Purpose of Disclosure:

☐ Continuing Care /Treatment	☐ Insurance	☐ Personal use by patient
☐ Family/Support Person	☐ Disability	☐ Other:___________________________
☐ School/Employer	☐ Legal/Law Enforcement	

Dates of Treatment: *(specify dates of treatment if known, or approximate date range)*

Covering the period of time from:______________________________to____________________________________

I authorize the following information to be shared:

☐ Discharge Summary	☐ Medication Record	☐ Continuing Care/Discharge Instructions
☐ Psychiatric Assessment	☐ Lab/Test Results	☐ Admission/Discharge Dates
☐ Clinical Assessments	☐ Psychologic Evaluation	☐ Verbal Communication only
☐ History and Physical Exam	☐ Treatment Plan	☐ Entire Record
☐ Consultation Reports	☐ Crisis/Safety/Relapse Plan	☐ Other:_____________________________

By signing this authorization, I understand that:

- I have a right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Dept. I understand that the revocation will not apply to information that has already been released in good faith in response to this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date signed, or unless another specific date or event has been provided.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- **Information in my health record may include information related to sexually transmitted diseases including HIV/AIDS. It may also contain information about treatment for alcohol and drug abuse.**
- Any disclosure of information carries with it the potential for unauthorized redisclosure by the recipient. Once released, the information may no longer be protected by Federal Privacy rules; however, HIV information and information related to substance abuse may not be redisclosed unless expressly permitted by the authorization or the federal regulations.

Patient's Signature:____ **Date:**__________________

Guardian/Parent Signature:____ **Date:**___________________

Witness Signature:____ **Date:**___________________

Rev: 5/2019