ROCKFORD CENTER
Responsive, Reliable, Respectful Behavioral Healthcare

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

(*Patient Label)*

Name	Date of Birth
Maiden/Prior Name(s):	Phone #
Address	City/State/Zip

I authorize the Rockford Center to: ☐ obtain information from ☐ release information to: ☐ Self (see address above)

Agency/Organization/Person	Relationship:
Address	City/State/Zip
Phone #	Fax #

Release information via: ☐ Mail ☐ Fax ☐ Pick up ☐ E-mail:_____ ☐ Verbal Exchange of Information ONLY

I am requesting release of my protected health information for the following purpose:

☐ Continuing Care /Treatment	☐ Billing/Insurance	☐ Child Custody
☐ School/Employer	☐ Disability Determination	☐ Personal use
☐ Family/Support Person	☐ Legal investigation	☐ Other:_____

Dates of Service Requested:_____

☐ I authorize the release of the following information <u>including</u> information related to any substance use disorder/substance use disorder treatment, or
☐ I authorize the release of the following information <u>excluding</u> information related to any substance use disorder/substance use disorder treatment, or

Only the information and records indicated below: (*Check all that apply and/or specify information needed if "Other" is checked)*

☐ Discharge Summary	☐ Continuing Care/Discharge Instructions	☐ Other:_____
☐ Psychiatric Evaluation	☐ Medication Record	_____
☐ History and Physical Exam	☐ Lab/Diagnostic Reports	_____
☐ Progress Notes	☐ HIV Test results/AIDS treatment records	_____
☐ Physician Orders	☐ Admission/Discharge Dates	

This authorization will expire on _____/_____/20_____. (*If not indicated, authorization will expire one year from signature date*.**)**

This form must be completed in full before signing:

Patient's Signature:_____ Date:_____

Parent/Legal Guardian Signature (if applicable):_____ Date:_____

Witness Signature/Credentials_____ Date:_____

This authorization is intended to allow the Rockford Center to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.
You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

Revocation Signature:_____ Date/Time_____