Authorization for Disclosure of Protected Health Information

ROGERS Behavioral Health

Rogers Behavioral Health – Illinois
34700 Valley Road
Oconomowoc, Wisconsin 53066
1-800-767-4411 select option "3"
Fax 1-262-646-5745

PLEASE COMPLETE ALL ITEMS ON THE FORM OR WE CANNOT RELEASE *If you have questions contact the above number.*

I authorize Rogers Behavioral Health – Illinois to: ☐ Disclose to: ☐ Obtain from:

1. PATIENT INFORMATION:		
PATIENT NAME	**PREVIOUS NAME**	**DATE OF BIRTH**
PATIENT STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
HOME TELEPHONE	**WORK TELEPHONE**	

2. FACILITY NAME RELEASE TO / OBTAINED FROM:		
AGENCY/FACILITY/PERSON		**RELATIONSHIP TO PATIENT**
STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
TELEPHONE NUMBER	**FAX NUMBER**	

3. SPECIFY THE INFORMATION TO BE DISCLOSED EITHER VERBALLY OR IN WRITING:

☐ **THE FOLLOWING INFORMATION CONTAINED IN MY HEALTH RECORD FOR THE DATE(S) OF SERVICE FROM** _____ **TO** _____ **(if no end date entered, will continue to apply through date of termination of this authorization):**

☐ Psychiatric Evaluation/Findings	☐ Psychological Findings	☐ Legal Status/Court Records
☐ Medications	☐ Psychosocial Assessment (PSA)	☐ Treatment Plans
☐ History & Physical/Medical Evaluation	☐ Educational Planning Information	☐ Laboratory/Radiology/EKG reports
☐ Personal Recovery Plan / Discharge Instructions	☐ Discharge Summary	☐ Other:

☐ **ENTIRE MEDICAL RECORD FOR THE FOLLOWING DATE(S) OF SERVICE FROM** _____ **TO** _____ **(if no end date entered, will continue to apply through date of termination of this authorization).**

For continuing care purposes, an Abstract will be sent including Discharge Summary, Psychiatric Findings, History & Physical, Consultations, Medications, Personal Recovery Plan (Discharge Instructions) and Diagnostic tests (lab, x-ray, EKG) if performed.

4. THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS SPECIFICALLY CHECKED BELOW:

☐ **HIV test results and related treatment** ☐ **Sexually transmitted diseases** ☐ **Genetic Testing**

☐ **Substance Use Disorder (SUD) treatment and/or referral ***

*** If authorizing the release of *SUD treatment and/or referral information*, please specify the information to be released (*Check all that apply*):**

☐ SUD assessments	☐ Aftercare plans	☐ Discharge summary including **SUD** information
☐ Treatment progress	☐ Treatment outcome	☐ SUD screen results
☐ SUD Medications	☐ Lab results related to SUD	☐ Other_____

☐ Compliance/non-compliance with recommended treatment plans, SUD screen results

5. RELEASE VIA: ☐ US MAIL ☐ FAX ☐ DIGITAL RELEASE _____ ☐ SECURE E-MAIL _____ ☐ PICK UP

6. EXPIRATION: This authorization expires on _____ *(insert date, time period or event)*. Unless otherwise designated, this authorization will expire at midnight one year from the date of my signature below.

7. PURPOSE OF DISCLOSURE: *(Check all that apply.)* ☐ Continuing care ☐ Insurance eligibility/payment of claims

☐ Obtain collateral information ☐ Personal reasons ☐ Verify compliance with treatment ☐ Other: _____
(Specify purpose)

8.. **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**: I authorize the release of copies of the health information described above. I understand that I may revoke this authorization; I must do so in writing and present my written revocation (**HIM-056 Cancellation of Authorization)** to the Health Information Department. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. **I understand that I may be charged a fee for copying, postage and preparation of records associated with fulfilling this request.** I understand that Rogers may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this authorization unless the services are being provided solely for the purpose of disclosing the information to a third party. **Redisclosure notice:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Regulations, but that all recipients of information related to alcohol and drug abuse patient records are informed of the prohibition against disclosure as required by the Confidentiality Regulations found at 42 C.F.R. Part 2. This authorization will be effective for health records generated during the time frame specified above, up to and including the date of expiration of the authorization. By signing this Authorization for Disclosure of Protected Health Information, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me. **Photocopy/facsimile copy is as valid as the original document**.

REDISCLOSURE NOTICE FOR RECIPIENT OF INFORMATION. If this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2), 42 CFR part 2 prohibits unauthorized disclosure of these records.

9. SIGNATURE OF PATIENT: _____ **DATE/TIME**: _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE/TIME**: _____

SIGNATURE OF ROGERS REPRESENTATIVE: _____ **DATE/TIME:** _____

If signed by a Legal Representative, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased

2. Legal authority: ☐ parent ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care