* Patient Name_____ * Date of Birth_____

* Address_____ Medical Record Number_____

* Phone Number_____

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION (evaluation, diagnosis, testing and /or treatment for alcohol and/or drug abuse [federally assisted programs], HIV or AIDS and mental health).

I hereby authorize that such health information regarding the above-named person be forwarded:

FROM: Person/Institution Advocate Medical Group
Address 701 Lee Street, Suite 100
City Des Plaines State IL Zip 60016

TO: (Recipient) Person/Institution IPHP, LLC
Address 701 Lee Street, Suite 125
City Des Plaines State IL Zip 60016

Purpose or need for information: Case Management

Disclosure will include the following verbal or written information: (*check all that apply*)

☐Face Sheet	☐History & Physical	☒Laboratory/Diagnostic Testing Results	☐School Information	
☐Discharge Summary	☐Medication Records	☐ Behavior Health/Psychological Consult	☐Psychological Evaluation/Testing Results	
☐ER Record Report	☐Psychiatric Evaluation	☐Psychosocial Assessment	☐Summary of Treatment Records and contact dates	
☐Substance Abuse Treatment Record		☐HIV Test Results	☒Other AMG IPHP Work Product	

* Records for the period (dates) from January 1, 1991 to February 28, 2017

I have a right to inspect and copy the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

EXPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date _____/_____/_____.

* _____ * _____
Signature of Patient **Date**

OR

_____ _____
Signature of Parent/Guardian/Legal Representative **Date**

_____
Relationship to the Patient (See Back of Form)

* _____ * _____
Witness **Date**

REDISCLOSURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.

Advocate Health Care®
AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION

Patient Label