ADIHEALTH

**AUTHORIZATION FOR USE or DISCLOSURE OF**
**MENTAL HEALTH/DEVELOPMENTAL DISABILITY INFORMATION**

Patient Name *(please print):* _____
Street Address: _____
City/State/Zip: _____
Birth Date: _____ Social Security #: _____ Phone #: _____

**I, _____ , do hereby authorize ADI Pediatric Behavioral Health to use and/or disclose mental health/developmental disability information to/from:**

Agency/Facility/Person: _____
Street Address: _____
City/State/Zip: _____ Phone #: _____

**The following information:**
**Check one**: ____ Complete Chart *(All Records)* ____ Abstract *(Documents Summarizing History & Pertinent Information)* ____ Outpatient Services *(Lab, X-ray, Cardiology)*
____ Other: _____
(*State specific nature of information to be disclosed*)

**Concerning the care provided during (dates of service):** _____
**For the purpose(s) of:** _____

- *I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing and should be addressed to the Health Information Management Department at the address listed above and must be witnessed by a person who can attest to my identity. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use disclosure have taken action in reliance on this authorization.*
- *I understand that I have the right to inspect and copy the mental health/developmental disability information that will be used or disclosed pursuant to this authorization.*
- *I understand that if the person(s) or organization (s) authorized to make the requested use and/or disclosure may not condition treatment payment, enrollment or eligibility for benefits, on execution of this authorization.*

**Patient's Signature**: _____ Date: _____
Signature of Minor (12-17 inclusive): _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Relationship to Patient: _____

Under the provisions of HIPAA and under the Illinois Mental Health and Development Disabilities Confidentiality Act, authorization for use/disclosure is voluntary. Individuals are not coerced into signing an authorization but provide the information freely. Once information is received by the authorized organization or person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Information is protected under Illinois law and may be subject to re-disclosure by the recipient only if permission for the re-disclosure is obtained. **Applicable fees will be charged for patients and attorneys.**

**This authorization will be valid for 365 days after the date of signing and limited to only that information I have requested above to be sent to the facility/person named herein and that it not be further disclosed or used for any purpose other than as stated in this authorization.**