CARLE ADDICTION RECOVERY CENTER
AUTHORIZATION TO RELEASE INFORMATION

Carle

X0605-0413
CARC0015_0413

Patient's Name _____ Birthdate _____

Street Address _____ Social Security # _____

City, State, Zip _____ Clinic # _____

Maiden/Other Names _____ Phone # (home) ( ) _____ (work) ( ) _____

I authorize **Carle Addiction Recovery Center** to **release/receive** (circle one or both) information, whether written or verbal, in my patient records as directed below:

1. **Name and address** of person(s) or organization(s) to or from whom, as applicable, disclosure is to be made. If multiple parties, see reverse side:

   Name _____

   Address (City, State, Zip) _____

2. **Purpose** of disclosure (please specify) _____
   (e.g., Patient's request, Patient evaluation)

3. **Dates** of Service: From _____ To _____

4. **Specific Records** to be disclosed:

☐ Medical Records	☐ Treatment Plans	☐ Secretary of State Verification Form
☐ Progress Notes	☐ Discharge Summary	☐ Other _____
☐ Psychosocial History	☐ Progress Update Letter	_____

5. By checking the box or boxes below, you authorize the release of the following information:

   ☐ Communicable disease and infection information, as defined by statue and Illinois Department of Public Health Rules (which includes venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC") and (specify other, if known) _____

6. **Revocation/Expiration.** This authorization can be revoked in writing at any time unless Carle Addiction Recovery Center has already acted upon your request. Submit your written request to Carle Addiction Recovery Center. Without expressed written revocation, this authorization expires 90 calendar days after it is signed, or upon the following specific date, event or condition _____

7. **Fees.** There may be a fee associated with the processing of this request. Please check with statffor estimated costs.

8. **Important Notice** THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS ARE PROTECTED BY ILLINOIS STATE LAW (20 IICS 301) AND FEDERAL LAWS AND REGULATIONS (42 CFR, PART 2). THE CONFIDENTIALITY LAWS AND REGULATIONS PROHIBIT THE DISCLOSURE OF THESE RECORDS UNLESS:

   1. THE PATIENT CONSENTS IN WRITING;
   2. THE DISCLOSURE IS ALLOWED BY A COURT ORDER AND SUBPOENA;
   3 THE DISCLOSURE IS MADE TO MEDICAL PERSONNEL IN A MEDICAL EMERGENCY OR TO QUALIFIED PERSONNEL FOR RESEARCH, AUDIT, OR PROGRAM EVALUATION. VIOLATION OF THE LAWS AND REGULATIONS IS A CRIME. SUSPECTED VIOLATIONS MAY BE REPORTED TO APPROPRIATE AUTHORITIES IN ACCORDANCE WITH THE LAWS AND REGULATIONS. FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD OR ELDER ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO APPROPRIATE STATE OR LOCAL AUTHORITIES.

My authorization to disclose the above information is voluntary, and Carle Addiction Recovery Center will not condition the provision of treatment on this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisdosure by the recipient and may no longer be protected by the laws and regulations applicable to Carle Addiction Recovery Center.

_____ _____
Patient's Signature (or Parent/Guardian/Authorized Signature where applicable) Date

_____ WITNESS _____
Authority to Sign, If not the patient

Records to be: ☐ Mailed ☐ Picked up

Use this side if multiple parties are being requested to release medical information.

I authorize the following parties/agencies to release and/or receive (as the case may be) information contained in my patient records, as indicated on the front side:

_____

_____

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