Release of Information Consent Form

PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____

I Authorize

Ad Astra Psychiatric Services

6624 N Fairfield Ave

Chicago, IL 60645

Phone: 708-232-6029

Fax: 866-811-6742

To:

- ☐ Release information to
- ☐ Obtain information from
- ☐ Exchange information with

The following person/organization

Organization Name: _____

Person Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Information to be released:

- ☐ Specific dates/years of treatment:
- ☐ All health information

OR

- ☐ Diagnosis
- ☐ Treatment Plans
- ☐ Medication History
- ☐ Social History
- ☐ Discharge Summary
- ☐ Other (provide specific information)

I UNDERSTAND THAT:

- My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Ellie Mental Health's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))
- Communications resulting from this authorization will reveal that I receive services at Ad Astra Psychiatric Services.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires Ad Astra Psychiatric Services to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- This authorization may be used by Ad Astra Psychiatric Services owned or managed programs upon transfer of my care to them.

SIGNATURE

Patient's Signature: _____Date:

OR Authorized Representative's Signature: _____Date:

Representative's Name (printed): _____

Representative's Relationship to Patient: _____