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

**Patient's Name:** *(Please Print)* _____

**Address:** _____

**City/State/Zip:** _____

**Birth Date:** _____ **Social Security #:** _____ **Phone #:** _____

**I,** _____ **, do hereby authorize Northwest Community Hospital/Day Surgery Center to use and/or disclose mental health/developmental disability information to:**

**Agency/Facility/Person:** _____

**Address:** _____

**City/State/Zip:** _____

**The following information:**

***Check One:***

☐ **Complete Chart** *(All Records)*

☐ **Abstract** *(Documents Summarizing History & Pertinent Information)*

☐ **Outpatient Services** *(Lab, X-ray, Cardiology If other, please specify)*

☐ **OTHER:** _____

***(State specific nature of information to be disclosed)***

**Concerning the hospitalization of (date(s) of discharge/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 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.*

_____

*It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any):*

_____

**Patient's Signature** _____ Date: _____

**Signature of Minor** (12-17 inclusive): _____ Date: _____

**Parent/Guardian/Representative Signature:** _____ Date: _____

**Relationship to Patient:** _____

**I attest to the identity of the above signature(s):**

**Witness:** _____ Date: _____

**Applicable fees will be charged for patients and attorneys**

*Under the provisions of HIPAA and under the Illinois Mental Health and Developmental 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.*
*This authorization will be valid for 180 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. Any person who discloses mental health records and communication without proper consent/authorization may be subject to civil liability or criminal penalty according to 740 ILCS et seq.*

**Northwest Community Hospital**
Arlington Heights, IL 60005

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NCH Item # 41156

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