North Central Behavioral Health Systems, Inc.

□ P.O. Box 1488
LaSalle, IL 61301
815-224-1610

□ 229 Martin Avenue
Canton, IL 61520
309-647-1881

□ 301 E. Jefferson St.
Macomb, IL 61455
309-833-2191

AUTHORIZATION TO DISCLOSE

I, (print legal name of client) _____ DOB: _____ NCBHS ID# _____
Authorize North Central Behavioral health Systems, Inc. to:

☐ **Release records to and/or**

☐ **Obtain records from**

Person/Agency receiving or obtaining information: _____

Address (Street/P.O. Box): _____

City, State, Zip Code: _____, _____, _____

Phone #, including area code: (_____) _____ - _____

FAX # (if applicable) (_____) _____ - _____

Unless otherwise specified by checking one of the following boxes, I authorize NCBHS to disclose information in writing and verbally. Check the applicable box if you choose to limit the means of disclosure: ☐ Written ☐ Verbally

□ By checking this box, I authorize and request that NCBHS disclose my confidential information electronically.

Specific Information to Be Disclosed (<u>required</u> - only items checked will be disclosed**)**

□	Discharge Summary	□	Psychiatric Evaluation/Medication Evaluation
□	Clinical Assessment	□	Medication Information
□	Risk Assessment	□	Correspondence
□	Level of Care Assessment (LOCA)	□	DUI Evaluation & Update
□	Emergency Assessment	□	DUI Risk Education
□	Periodic Court Summary	□	Secretary of State Treatment Verification
□	Progress Notes	□	Appt. Info. (Dates/Times/Locations/Staff/Status)
□	Individual Treatment Plan	□	Other Information as listed:
□	Diagnosis Review		_____
			_____

NCBHS will not re-disclose information received from another provider/entity.

Please indicate date of service for requested records if known. _____
(Note: Unless otherwise requested, only records from the past twelve months will be disclosed)

Purpose or need for disclosures: (required)

☐	Continued Treatment	☐	Reports to the Legal System or DCFS
☐	Insurance Benefits	☐	Other_____

I understand that:

- Any information released or requested by either authorized person or organization is not to be re-disclosed without written authorization.
- This authorization will expire on the following date _____/_____/_____, one year from the date of the client /guardian signature below **OR** upon discharge from treatment, <u>whichever occurs first</u>.
- This authorization is subject to revocation at any time by delivery of signed and witnessed Revocation of Authorization form to NCBHS except to the extent that action has been taken in reliance thereon and except as disclosure is allowed as described in the NCBHS Notice of Privacy Practices.
- Refusal to authorize may result in delays, duplications, and other problems that may affect the quality of services that the agency provides.
- I have the right to inspect and to copy the information to be disclosed.
- The federal regulations of Confidentiality of Alcohol and Drug Abuse Patients Records (42 CFR Part 2) and the Illinois Department of Mental Health and Developmental Disabilities Confidentiality Act, and the Health Portability and Accountability Act, control the disclosures of information and that they have been explained to me.

□ Client (over 12):	_____ Signature	_____ Date
□ Parent of Minor Child:	_____ Signature	_____ Date
□ Legal Guardian:	_____ Signature	_____ Date
□ Personal Representative:	_____ Signature	_____ Date
□ Witness:	_____ Signature	_____ Date

This information is requested under the assumption that no processing fees will be assessed. If a fee will be charged, please call (815) 224-1610 and ask to speak with our Clinical Records Department.

For NCBHS Office Use Only

□ Please Send Records □ Please Request Records □ For File

INSTRUCTIONS:

All areas must be completed for the authorization to disclose to be valid. No records can be released without a valid authorization to disclose.

Fill in your complete legal name. If you were seen at NCBHS under a different name, please also include that name.

Enter your date of birth to help us ensure that we have the correct individual.

Check the applicable box indicating whether you are authorizing information to be "released to" or "obtained from", or both.

Fill in the information identifying the name of the person/agency the authorization is to be sent to, address, telephone number and FAX number if applicable.

If you choose to restrict the disclosure of information to specifically "written" or "verbally" check the applicable box.

Check the applicable box for disclosing of information electronically only if you are authorizing and requesting that your confidential information be disclosed via electronic means.

Check the specific information boxes as applicable for the information that you want to be disclosed. If additional information is needed but not listed, please check the "Other" box and specify the exact information to be disclosed. Only the information checked will be disclosed.

Check the applicable box identifying the purpose or need for the disclosure. If no boxes apply, check the "Other" box and specify the reason for the request.

Specify the date(s) of service if you want more or less than the last 12 months of information to be disclosed.

If the authorization is to expire on a specific date, the month, day and year must be entered. If no date is entered, the authorization will automatically expire one year from the date of the client/guardian signature. In no case will an authorization be valid for more than one calendar year. All authorizations will become invalid when an individual is discharged from treatment with NCBHS.

The signature of the client, parent of minor child, legal representative (i.e. Power of Attorney for Healthcare) or legal guardian and date of signature must be included. The signature(s) must be witnessed by an adult. NCBHS reserves the right to require a client/guardian signature to be notarized if the Authorization to Disclose is completed outside of NCBHS.

The signature of the witness and date is required. All signatures dates must be the same.

If an error is made on the form, the incorrect information must be crossed out and corrected information initialed by the authorized individual. Authorizations that have information scratched out and/or blocked out with a correction fluid will not be accepted.

Authorizations should be completed in black ink. Authorizations completed in pencil will not be accepted.

Faxed Authorizations to Disclose can be accepted on a temporary basis. Please forward the original Authorization to Disclose to NCBHS.