Authorization to Use and/or Disclose Protected Health Information

I, ____, authorize Creekwood Associates to:
CLIENT NAME (PRINT) DOB (MM/DD/YYYY)

☐ disclose information to ☐ obtain information from ☐ disclose to and obtain from

Name of Person/Facility____

Street Address/City/State/Zip______________________________________

Phone/Fax/Email: ____

I authorize the following information to be shared:

- ❏ Psychiatric Evaluation/Assessment
- ❏ Diagnosis
- ❏ Recent Physical Exam Records
- ❏ Mental Health/Crisis Assessment
- ❏ Psychiatric or Progress Notes
- ❏ Mental Status Exam
- ❏ Medical/Medication Information
- ❏ Psychological Evaluation/Test Results
- ❏ Discharge Summary
- ❏ Most Recent Contact/Progress
- ❏ Treatment Plan/Summary
- ❏ Recommendations
- ❏ Attendance
- ❏ Financial
- ❏ Insurance

Initial, if the following will be disclosed:

______ Mental Health/Developmental Disabilities information and/or records
______ HIV/AIDS related information and/or records
______ Drug/Alcohol diagnosis, treatment and/or referral information

Information shared will be for the purpose off:

- ❏ Continuity of care and treatment planning
- ❏ Family Involvement
- ❏ Referral/Determine Eligibility for Services
- ❏ Other:______________________________

Information may be shared by phone call, fax, mail, in person, or email.

Restrictions, if any: ____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information regarding mental health and developmental disabilities, substance use/abuse or AIDS under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Substance Abuse Confidentiality Requirements, and the Illinois AIDS Confidentiality Act. I understand that the named agency/facility/individual authorized to receive the information has the right to inspect and copy the information disclosed.

I also understand that the person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

This authorization will remain in effect: ☐ indefinitely until revoked in writing ☐ until date specified: ________________

____
Patient Name (PRINT) Signature (ages 12+ required) Date

____
Guardian Name (PRINT) Signature Date

____
Witness Name (PRINT) Signature Date