CHESTNUT HEALTH SYSTEMS

DISCLOSURE AUTHORIZATION

PATIENT INFORMATION	
NAME:	DATE OF BIRTH:
ADDRESS:	CITY, STATE, ZIP:

I understand that by signing this form, I agree to allow CHESTNUT HEALTH SYSTEMS, INC. ("CHESTNUT") to obtain from and release to the individuals or entities named below the information described below. I also understand that if I choose not to sign this form, none of my health information will be shared, and that CHESTNUT cannot condition my treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this form. I understand that unless I have specifically requested in writing that the disclosure be made in a specific format, CHESTNUT reserves the right to disclose information in any manner that it deems appropriate and consistent with applicable law.

THIS FORM MEETS ALL REQUIREMENTS OF THE FEDERAL CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATIONS (42 C.F.R. PART 2), THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT (740 ILCS 110/5), AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (45 C.F.R. PARTS 160 AND 164).

WHO MAY DISCLOSE AND RECEIVE INFORMATION. I authorize CHESTNUT and entities listed below to disclose my health information.

WHAT MAY BE DISCLOSED - to include ☐Mental Health, ☐Substance Use, and/or ☐HIV Information)

Check the types of information you want shared:

☐ my demographic information
☐ my financial information
☐ my insurance information
☐ my necessary medical equipment
☐ my immunization record
☐ my allergies or other alerting data
☐ my presence and participation in treatment
☐ my medications
☐ my medical procedures
☐ my discharge/transfer summaries
☐ my provider's progress notes
☐ my treatment plans
☐ my symptoms and diagnosis
☐ my health status in an emergency
☐ my assessment information
☐ my vital signs
☐ my psychiatric evaluations
☐ my educational information
☐ my laboratory results (including urine and other drug screens)
☐ OTHER: _____

WHO MAY RECEIVE: I authorize CHESTNUT to ☐Disclose Health Information, and/or ☐Receive Health Information From:

I. ☐ **INDIVIDUALS** - *Any individual, include the name of the individual, relationship, and contact information.*

a. _____

b. _____

II. ☐ **TREATING PROVIDER ENTITIES -** ☐Past ☐Present ☐ Future *(Check all that apply)*

Any entity with a treating provider relationship, include the name of the entity/provider and facility with contact information:
(Select applicable boxes below)

☐ Hospital *(specify)*: _____
☐ Federally Qualified Health Center *(specify)*: _____
☐ Primary Care Practice *(specify)*: _____
☐ Other Medical Practice *(specify)*: _____
☐ Community Health Center *(specify)*: _____
☐ Behavioral Health Organization *(specify)*: _____
☐ Substance Use Disorder Program *(specify)*: _____
☐ Other *(specify)*: _____

III. ☐ **NON-TREATING ENTITIES -** *Any entity without a treating provider relationship, include the name of the entity/provider and facility **and** name of individual(s) within the entity and contact information*
(Select applicable boxes below)

☐ Health Information Exchange *(specify)*: _____
☐ Accountable Care Organization *(specify)*: _____
☐ Court *(specify)*: _____

☐ Police *(specify)*: _____
☐ Probation *(specify)*: _____
☐ Parole *(specify)*: _____
☐ Employer *(specify)*: _____
☐ School *(specify)*: _____
☐ Law Office *(specify)*: _____
☐ Government Agency *(specify)*: _____
☐ Other *(specify)*: _____

IV. ☐ **THIRD PARTY PAYER** ***(Required for SUD)*** *- Any payer, include the name of the entity.*

a. _____
b. _____

PURPOSES: I authorize the above disclosure of my health information for the following purposes (C*heck all that apply*):

☐ to help with my treatment
☐ to improve my provider's operations
☐ to help coordinate my health care
☐ to involve family and significant others in my treatment
☐ to complete evaluations
☐ for purposes of visitation or communication with me
☐ for purposes of payment for my care
☐ Other: _____

EXPIRATION. This authorization will expire on: _____
(*Insert exact date, not to exceed 1 year from the date signed)*

REVOCATION. I understand that I may revoke this authorization in full or in part at any time by providing written notification to CHESTNUT. However, my revocation will not cover disclosures of my health information that CHESTNUT already made before my revocation.

INSPECTION. I understand that I have a right to inspect and copy my health information that is disclosed.

FEDERAL LAW. The information that I am permitting to be disclosed may be from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient	Date	
Signature of Parent/Guardian or Personal Representative	Date	Type of Authority to Act for Patient
Signature of Witness	Date	

TO BE COMPLETED BY OFFICE
☐ Patient has been given the opportunity to see, review and inspect the signed Disclosure Authorization form.