ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center
1 S. 376 Summit Ave., Court D, Unit 5B
Oakbrook Terrace, IL 60181
Dr. Burda: (630) 629-2700
Physicians: (630) 629-6550
FAX: (630) 629-6558

Hinsdale Professional Office Center
501 W. Ogden Ave., Suite 1
Hinsdale, IL 60521
Therapists: (630) 986-0599
Fax: (630) 986-1477

Authorization to Disclose/Obtain Information

1. I authorize_____ (doctor, clinician, agency, individual) to ___disclose, ____obtain _____disclose and obtain

2. _____Discharge Summary ____Psychiatric Evaluation _____Psychological Test Report
_____Psychological Evaluation ____Progress Notes _____Medical Administration Records
_____Consultations ____History and Physical _____Social History
_____Behavioral Plans ____Treatment Plans _____Other (please describe_____)

3. About (Patient Name)_____ Date of Birth:_____

4. For purposes of: _____Personal Use _____Continuity of Care _____Financial/Benefits
_____Attorney _____State Law/Court _____Other
(please describe_____)

5. Information may be disclosed/obtained: Mail, In-person, Phone, E-Mail or by Fax (For urgent needs)
Restrictions if any:_____

6. ___disclose to _____obtain from _____disclose to and obtain from
Name:_____
Address_____
City, State, Zip Code_____
Phone Number_____

7. This authorization is valid until calendar date _____(month/day/year)

8. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

9. I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to Advanced Behavioral Centers of Dupage staff. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

10. Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED

11. It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDS unless specifically checked below for exclusion:

____Mental Health _____Alcohol/Substance Abuse _____HIV/AIDS _____Developmental Disabilities

_____ _____
(DATE/TIME) (PATIENT SIGNATURE)
REQUIRED if Patient is 12 years or Older

_____ _____
(DATE/TIME) (SIGNATURE OF PARENT OR GUARDIAN)
If Patient is Under 18 or Disabled

_____ _____
(DATE/TIME) (SIGNATURE OF WITNESS)
second parent/guardian, if co-custodial, may sign here)

_____ _____
(DATE/TIME) (SIGNATURE OF STAFF PERSON DISCLOSING/OBTAINING INFORMATION)