Pillars Community Health
Healing. Caring. Educating.

Administrative Office: **5220 East Avenue** **708-745-5277**
Countryside, IL 60525

Authorization of Release of Confidential Information

I, _____ (client), whose Date of Birth is _____,

authorize Pillars Community Health to disclose to and/or obtain from:

_____
(name and address of person or title of person or organization)

the following information:

Description of Information to be Disclosed (client will initial each item to be disclosed)

____	Assessment	____	Nursing/Medical Information
____	Diagnosis	____	Toxicological Reports/Drug Screens
____	Psychosocial Evaluation	____	Educational Information
____	Psychological Evaluation	____	Discharge/Transfer Summary
____	Psychiatric Evaluation	____	Continuing Care Plan
____	Treatment Plan or Summary	____	Progress in Treatment
____	Current Treatment Update	____	Demographic Information
____	Medication Management Information	____	Other _____
____	Presence/Participation in Treatment	____	Other_____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:_____
_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Keeper of Records at Pillars Community Health. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires on the following date:_____
or otherwise indicated:_____
If a calendar date is not stated, information may only be released on the date the authorization is received.

Conditions: I further understand that Pillars will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:_____
_____

Client ID #:

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. Seq.).

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of the authorization for my records.

_____ _____
Signature of Client (12 years and older) Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ Check here if client refuses to sign authorization.

_____ _____
Signature of Staff Witness Attesting to Identity and Authority Date

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REVOCATION

I, _____ (client), revoke my authorization of release of confidential information.

_____ _____ _____
Signature of Client (12 years and older) Date

_____ _____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____ _____
Signature of Staff Witness Attesting to Identity and Authority Date

Client ID #: