OSF HealthCare
Cardiovascular Institute

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MRN (Office Use Only)

Authorization for Release of Mental Health / Developmental Disability Information

____ __________________________________
Patient Name – Please Print | Birth Date

____ __________________________________
Street Address | City / State / Zip

____ __________________________________
SSN | Phone

I hereby authorize (enter OSF office) to disclose to:

____
Name of Person or Agency

____
Street Address

________________________________ Phone:____________
City / State / Zip

The following information (check all boxes that apply):

☐ Treatment ☐ Progress ☐ Session Notes

Circle those that apply: Labs Radiology Consult Report Immunizations

Records regarding __________________________**(specific event) Other:**_______________________________

Concerning treatment from: ___________________________________ **to:** ________________________________
Date Date

This disclosure is made for the purpose of: ____
Please Print (All purposes must be fully described)

- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. However, this information will continue to be protected by Illinois Law, and may be subject to re-disclosure by the recipient ONLY if I specifically provide permission for the re-disclosure.
- I understand that this authorization is voluntary. I understand that the person(s) or organization(s) authorized to make requested use and / or disclosure may not condition the provision of treatment on the provision of an authorization.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the office authorized above to make the release. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date: _____________________. If I do not specify an expiration date, this authorization will expire 12 months from the signature date.

____ _________________________
Patient's Signature (age 12 or over) [Required] | Date

____
Parent/Guardian (Print Name & Relationship) (For patients under age 12)

____ _________________________
Parent/Guardian Signature | Date

____
Name of Witness (Print Name) who can attest to identity of signatory

____ _________________________
Signature of Witness who can attest to identity of signatory | Date

Request Completed on (date)______________________________ Initials of Employee Completing Request________

Created: 01/05; Revised: