

**MATHERS CLINIC, LLC****MATHERS RECOVERY****MATHERS CMHC****BEHAVIORAL HEALTH AUTHORIZATION TO DISCLOSE AND/OR OBTAIN HEALTH INFORMATION**

Please Fax Any Correspondence To: 815.986.1363

PATIENT NAME: \_\_\_\_\_ MRN: \_\_\_\_\_  
Last Name First Name MIPATIENT ADDRESS: \_\_\_\_\_  
Street Address City State ZipDATE OF BIRTH: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_  
Month/Day/Year Please Include Area Code**The undersigned hereby authorizes and requests:**

- Mathers Clinic, LLC  
 Mathers Recovery  
 Mathers CMHC  
 Other \_\_\_\_\_

*\* Please use the separate **Authorization for Release Of Information Form** when requesting records from Mathers Clinic, Mathers CMCH and Mathers Recovery.*

**To Disclose and provide the requested information to**

OR

**To Obtain the requested information from**

(please circle one)

\_\_\_\_\_  
Individual/Facility/Entity To Be Released To\_\_\_\_\_  
Street Address\_\_\_\_\_  
City State Zip\_\_\_\_\_  
Telephone Number**Health Information To Be Disclosed:**

Date(s) of Treatment:

- |  |  |  |
|--|--|--|
| <input type="radio"/> <b>Entire Medical Record</b>   | <input type="radio"/> Billing/Insurance/Financial/Account Status | <input type="radio"/> Completion Paperwork           |
| <input type="radio"/> Court Orders/Documents         | <input type="radio"/> Crisis Records                             | <input type="radio"/> Discharge Summary              |
| <input type="radio"/> Attendance Records             | <input type="radio"/> History/Physical                           | <input type="radio"/> Labs (specify):                |
| <input type="radio"/> Medication Information         | <input type="radio"/> Phone Conversation                         | <input type="radio"/> Police Reports                 |
| <input type="radio"/> Psychological Evaluation       | <input type="radio"/> Psychiatric Evaluation                     | <input type="radio"/> School Reports/Testing         |
| <input type="radio"/> Substance Abuse/DUI Evaluation |  | <input type="radio"/> Treatment Plans/Discharge Plan |
| <input type="radio"/> Other                          |  |  |

I fully understand and acknowledge that my medical record may contain information relating to mental health, developmental disabilities, alcohol/drug abuse and/or Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) test results or other sensitive information, and I expressly authorize the release of any such information contained in records designated above. I understand that re-disclosure of the information disclosed pursuant to this authorization is prohibited unless the person who consented to the disclosure specifically consents to the re-disclosure. However, once the information is disclosed, there is potential that it may be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws and regulations. MATHERS CLINICS is not responsible for any re-disclosures of health information or medical records. I understand that records and communications shall remain confidential after the death of the patient and shall not be disclosed unless the patient's representative and therapist consent or disclosure is authorized by court order. I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy/confidentiality protections.

As described in MATHERS CLINICS Notice of Privacy Practices, I understand and acknowledge that for the purposes of third party payment to MATHERS CLINICS that diagnostic and therapeutic information may be required to process payment and will be disclosed to my insurance company and/or the insurance company's review agency and no authorization is required for such disclosure unless I choose to pay for services in full and out-of-pocket at the time such services are rendered. I understand that this authorization is voluntary and MATHERS CLINICS will not condition treatment, payment, enrollment or eligibility for benefits on this authorization.

I may inspect and arrange for photocopies of records/health care information that are to be disclosed. I understand that I may be responsible for costs associated with obtaining copies of my records. I may revoke this authorization at any time, except to the extent that action has been taken in good faith reliance on this authorization, by submitting a written revocation to MATHERS CLINICS, 145 S. VIRGINIA ST, CRYSTAL LAKE, IL 60014.

Unless otherwise revoked, this authorization will expire within one (1) year from the date of signature on \_\_\_\_\_ or other event.  
DATE

PATIENT/REPRESENTATIVE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If a personal representative is signing this authorization, please attach document(s) of the personal representative's authority to action on behalf of the patient, if required.

\*\* Patient 12-17 must sign authorization.

WITNESS/PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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