

Illinois Professionals Health Program

I, _____, do hereby consent to and authorize **THE ILLINOIS PROFESSIONALS HEALTH PROGRAM** (IPHP) to disclose to:

(Person/Institution)

(Address, City, State, Zip)

(Telephone)

(Fax)

Information in its possession relating to my identity, diagnosis, prognosis or treatment. I understand that the specific type of information to be disclosed includes:

Participation in the IPHP Monitoring/Aftercare Agreement Compliance with Agreement Verbal Contact

Toxicology Results Diagnosis Other (Please Specify) _____

Purpose or Need for Data: case management and advocacy

Special Authorization for Release of Mental Health and Alcohol or Drug Abuse Case Management/Patient Records/ HIV

I FURTHER AUTHORIZE THE PERSON/INSTITUTION NAMED ABOVE TO RELEASE TO THE ILLINOIS PROFESSIONALS HEALTH PROGRAM THE FOLLOWING INFORMATION:

- | | | |
|---|--|---|
| <input type="checkbox"/> Multidisciplinary Assessment | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychiatric and Psychological Evaluation | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Treatment Compliance | <input type="checkbox"/> Progress |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Toxicology Results | <input type="checkbox"/> Monitoring Agreement |
| <input type="checkbox"/> Work Performance/Behavioral Concerns | <input type="checkbox"/> Toxicology Compliance | <input type="checkbox"/> Legal/Licensure Status |
| <input type="checkbox"/> Credentialing/Staff Privileges Status | <input type="checkbox"/> Status with Program | <input type="checkbox"/> Verbal Contact |

Other (Please Specify): _____

Date: _____ **SS#:** _____ - _____ - _____ **DOB:** _____ / _____ / _____

Signature of Participant: _____

(Address, City, State, Zip)

Witness: _____ **Date:** _____

It is understood that this authorization is subject to revocation by me at any time in writing except to the extent that action has already been taken to release this information. This authorization shall remain valid until revoked and will expire ____/____/____. It is understood that if I do not sign this authorization, the institution named above will not release my medical records.

PROHIBITION ON REDISCLOSURE: I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing confidentiality and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Federal Regulation (42 CFR, Part 2) and state law prohibit any further disclosure of this information except with the specific written consent of the person to whom it pertains. I understand that generally IPHP may not condition my participation on whether I sign a consent form, but that in certain limited circumstances I may be denied participation if I do not sign a consent form.