Montes Psychiatric Center, P.C.

BEHAVIORAL HEALTH AUTHORIZATION TO DISCLOSE AND/OR OBTAIN HEALTH INFORMATION

Please Fax Any Correspondence To: 815.839.8290

PATIENT NAME: _____
Last Name First Name MI

PATIENT ADDRESS: _____
Street Address City State Zip

DATE OF BIRTH: _____ TELEPHONE NUMBER: _____
Month/Day/Year Please Include Area Code

The undersigned hereby authorizes and requests: Montes Psychiatric Center, P.C. 6090 Strathmoor Drive, Suite 1 Rockford, IL 61107 Phone: (815) 839-8180 Fax: (815) 839-8290	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 / Fax Number

Date(s) of Treatment:

Health Information To Be Disclosed:

O Entire Medical Record	O Court Orders/Documents	O Psychological Evaluation
O Billing Information	O Discharge Summary	O School Reports/Testing
O Phone Conversation	O Attendance Records	O Medication Information
O Completion Paperwork	O Other	

I fully understand and acknowledge that my medical record may contain information relating to mental health, developmental disabilities, alcohol/drug abuse and/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 MONTES PSYCHIATRIC CENTER, P.C. Notice of Privacy Practices, I understand and acknowledge that for the purposes of third party payment to MONTES PSYCHIATRIC CENTER, P.C. 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 MONTES PSYCHIATRIC CENTER, P.C. 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 MONTES PSYCHIATRIC CENTER, P.C., 6090 Strathmoor Drive,Suite 1, Rockford, IL 61107.

Unless otherwise revoked, this authorization will expire within one (I) 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: _____

MONTES PSYCHIATRIC CENTER, P.C.

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Suite 1
Rockford, IL 61107

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