Wight Care Clinic
David A. Wight, M.D.
BEHAVIORAL HEALTH AUTHORIZATION TO DISCLOSE AND/OR OBTAIN HEALTH INFORMATION

Please Fax Any Correspondence To: 815-395-1775

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:
Wight Care Clinic
David A. Wight, M.D.
7019 Rote Rd, Ste 105
Rockford IL 61107
Phone: 815-381-0900
Fax: 815-395-1775

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:_____

Purpose of Release:
The purpose of this disclosure of information is to share treatment information and to coordinate care.
If other purpose, please specify: _____.
In the event of a disclosure necessary for emergency notification, Wight Care Clinic will disclose that the patient is participating in treatment.

Information to be Disclosed: __ **Complete Record**

__Medical/Psychiatric/Medication
__Reviews
__Lab Reports
__Assessments
__Progress Reports
__Treatment Plans/Treatment Plan
__ Discharge Summaries
__ Presence in treatment only
__ Other_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Wight Care Clinic. 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

This authorization will expire on the following date: _____. If I do not specify an expiration date, this authorization will expire one year from the date of execution of this authorization.

Conditions

I further understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. Wight Care Clinic will not condition my treatment on whether I give authorization for the requested disclosure. I also have right to inspect and copy the information that is to be released.

Form of Disclosure

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, by facsimile, or electronically. Wight Care Clinic does not use encryption technology for e-mail and therefore, information being transmitted via e-mail may be viewed by unauthorized persons during transmission. I understand that it may be impossible to determine whether unauthorized access to e-mail has taken place.

Redisclosure

Federal and State 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 and the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Anyone who receives information will not be able to disclose the information without your consent.

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 the 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 records may not be protected by the state and federal privacy laws and regulations. Wight Care Clinic 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. I understand and acknowledge that for the purposed of third party payment to Wight Care Clinic, 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 Wight Care Clinic will not condition treatment, payment, enrollment, 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 Wight Care Clinic, 7019 Rote Rd., Ste 105, Rockford, IL 61107. I understand that I may be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

Unless otherwise revoked, this authorization will expire within one (1) year from the date of signature _____ _____ or other event.
Date

PATIENT/REPRESENTATIVE SIGNATURE :_____DATE:___ _____

If a personal representative is singing 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:_____

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTDISABILITIES CONFIDENTIALITY ACT, AND 45 CFR PARTS 160 & 164 (HIPAA)

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