Trinity Medical Center/Robert Young Center/Center for Alcohol and Drug Services, Inc.
Downtime Consent and Authorization for Release of Information 08/19

Robert Young Center	Riverside/Access Center	Community Support Program	Center for Alcohol & Drug Services, Inc
4600 3rd Street	2701 17th Street	2200 3rd Avenue	1523 S. Fairmount St.
Moline, IL 61265	Rock Island, IL 61201	Rock Island, IL 61201	Davenport, IA 52802

This authorization is valid until calendar date: _____ (no more than 1 year from date signed).
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. This revocation of consent for release must be in writing, dated and witnessed. I understand that I have the right to inspect and copy the information to be disclosed upon the proper notification to and under conditions established by Trinity Regional Health System. I understand the terms of this authorization for release of my information. I understand that if a general designation is used in the "To Whom" section of this authorization to release my information, I have the right to obtain, upon request, a list of entities to whom my information has been disclosed pursuant to the general designation. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations.

I, _____, authorize Robert Young Center/Riverside/Community Support Program/CADS to: ☒ release to, ☐ request from or ☐ verbally exchange with the following facility or person ☒ via Mail, ☐ Telephone or ☒ Fax. Fax # (309) 796-2911

Name: Black Hawk Area Special Ed District Attn: Don Kearney
Address: 4670 11th Street
City, State Zip Code: East Moline, IL. 61244

Type of Records to be Released

☒ Mental Health ☐ Substance Use Disorder

Information Requested for Service Dates _____ **to** _____

- ☐ Confirmation of contact
- ☒ Treatment plan
- ☒ History and physical
- ☒ Discharge summary
- ☐ Laboratory and X-Ray reports
- ☐ Alzheimer Diagnostic evaluation (CERAD)
- ☐ Frequency & Duration of Contact with Program
- ☒ Results of Evaluation, Recommendations, Plans
- ☐ Information relating to Client Emergency
- ☐ Urinalysis Results
- ☒ Other: Diagnosis, Medications and Restrictions.
- ☐ **To release any results from HIV testing or any AIDS related diagnosis**
- ☐ **Redisclose Information from:** _____
- ☐ DUI/SOS
- ☒ Psychological evaluation/testing
- ☒ Psychiatric evaluation
- ☒ Diagnostic assessment
- ☒ Progress notes
- ☐ Social History
- ☐ Legal History
- ☐ Iowa Provider Network Critical Incident Report

Purpose of Release

- ☒ Treatment Planning
- ☐ Insurance Coverage
- ☐ Inform contact person in event of emergency
- ☒ Other: Eligibility for DHS/DRS
- ☒ Continuity of Care
- ☐ Legal Proceedings
- ☐ Facilitate Overall Case Planning
- ☐ Report Critical Incident

The possible consequences of refusing to grant this authorization could be inadequate treatment planning, continuity of care or reimbursement issues. I understand that my healthcare will not be affected should I choose to cancel or refuse to sign this authorization. I agree to pay for healthcare services if my insurance company denies claims because I canceled or refused to sign this form.

Prohibition on Redisclosure
This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 CFR Part 2) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Client Signature (Minor's signature if 12 through 17) _____ **Date** _____

Parent/Guardian Signature _____ **Relationship to Client** _____ **Date** _____

Witness (Invalid document if signature is not witnessed) _____ **Date** _____

Client Name:	DOB:	MRN:
Date:	1 of 1	