rosecrance®
Jackson Centers

Authorization For The Release Of Confidential Information

PATIENT NAME: _____ **DOB:** _____

I hereby authorize Jackson Recovery Centers to ☐ RELEASE TO and/or ☐ RECEIVE FROM:

_____

(entity/organization only allowed for treating providers or third-party payers; all others must include named individuals)

The following information (Please check specific items):

☐ Any/all of my medical records or specifically:

- ☐ Only to confirm that I am a patient or no longer a patient
- ☐ Dates and times of my attendance/no shows.
- ☐ Assessment information, diagnosis, testing results, recommendations, and arrangements for services, if any.
- ☐ Psychosocial history.
- ☐ Overall progress reports.
- ☐ Educational progress reports (adolescent only).
- ☐ Psychiatric/psychological evaluation and testing.
- ☐ Treatment plan, plan reviews; and continuing stay reviews.
- ☐ Discharge summary.
- ☐ Medical information including history and physical, TB screen, lab tests/reports, medications taken and/or prescribed, immunization record, and progress reports.
- ☐ Financial information including income documentation, balance(s), financial arrangements, insurance information.
- ☐ OTHER: _____

Specific to: ☐ Current admission ☐ Previous admission(s): _____(specify)

I specifically authorize the release of the information listed below, which requires specific consent under federal and state law (initial):

Substance Use Disorder: _____ Mental Health: _____ HIV related information: _____

I understand this information will be used for: ☐ Continuity of care ☐ Payment/Insurance ☐ Legal ☐ Other _____

I hereby authorize the release of information as set forth above.

- I understand my records are protected under State and Federal Confidentiality Regulations (42 CFR Part 2, 45 CFR pts 160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand this authorization is voluntary and I may revoke this consent at any time by sending written notice to Rosecrance Jackson Centers. Disclosure made prior to revocation shall not constitute a breach of confidentiality. Disclosure carries the potential for redisclosure of this information by other entities who receive that information.
- I understand that a recipient of information may not further disclose this information except with my written authorization or as otherwise provided in 42 CFR part 2 and IAC Chapters 228 and 229.
- I understand Jackson Recovery Centers may not require completion of this form as a condition of service, except when the service is solely to create and release a report containing confidential information.

This authorization expires automatically one year after it is signed or on: _____, unless expressly revoked.
(date, event, or condition)

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if minor): _____ Date: _____

Please send records to the following requesting Jackson location: _____

Jackson Staff Only: ☐ Release sent via FAX or MAIL to RECEIVE outside records Date: _____ Initials: _____
☐ File in chart only
☐ Release scanned in chart and request sent to Medical Records Dept to SEND records