Trinity Medical Center/Robert Young Center
Consent and Authorization for Release of Information

Robert Young Center
4600 3rd Street
Moline, IL 61265

Riverside/Access Center
2701 17th Street
Rock Island, IL 61201

Trinity Enrichment Center
4622 Progress Drive Suite A
Davenport, IA 52807

This authorization is effective for one year from the date on which it was 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 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 to [X] release to, [ ] request from and [X] verbally exchange with the following facility or person:

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

Information Requested for Service Dates _____ to _____

- [X] Confirmation of contact
- [X] Treatment plan
- [X] History and physical
- [X] Discharge summary
- [ ] Laboratory and X-Ray reports
- [ ] Alzheimer Diagnostic evaluation (CERAD)
- [ ] Other: _____
- [ ] **To release any results from HIV testing or any AIDS related diagnosis**
- [ ] Records relating to substance abuse (drug or alcohol)
- [ ] DUI/SOS
- [X] Psychological evaluation/testing
- [X] Psychiatric evaluation
- [X] Diagnostic assessment
- [X] Progress notes

Purpose of Release

- [X] Treatment planning
- [ ] Insurance coverage
- [ ] Other: _____
- [X] Continuity of care
- [ ] Legal proceedings

The possible consequences of refusing to grant this authorization could be inadequate treatment planning, continuity of care or reimbursement issues. I understand my healthcare and payment for my healthcare will not be affected by this authorization.

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:	MR#:
Date:	1 of 1	