1024 W Main St
St Charles, IL 60174
Main: 630-262-2640
Fax: 630-262-2645
www.InStep360.org

PATIENT AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____Date of Birth:____/____/_____

SELECT FROM THE FOLLOWING OPTIONS BELOW:

- ☐ I authorize the release of medical information **FROM** In Step Behavioral Health
- ☐ I authorize to release medical information **TO** In Step Behavioral Health.

RELEASE APPLIES TO INDIVIDUAL OR CORPORATION:

Name:_____

Address: _____

City:_____State:_____ ZIP Code: _____

Phone #: (_____)_____ Fax #: (_____) _____

- ☐ My entire Medical records pertaining to my mental health **including** therapy notes.
- ☐ My entire Medical records pertaining to mental Health **excluding** therapy notes.

From Date of service_____to _____

PURPOSE:

□ Personal Records □ Continue Care □ Legal □ Insurance □ Medications □ Progress in Treatment □ Diagnosis □ Alcohol and Drug Evaluation □ Background Information □ Recommendations □ Other (specify) _____

- I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed, as described above, may no longer be protected by these laws and may be re-disclosed.
- I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment, or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.
- I understand that I have the right to inspect or copy any of the information disclosed by this authorization.
- I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that IN STEP BEHAVIORAL HEALTH, S.C. has already acted in reliance upon this authorization as shown by my signature below and as explained in the Notice of Privacy Practices.
- I understand that IN STEP BEHAVIORAL HEALTH, S.C. and its employees are released from any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.
- I understand that I may request a copy of this signed authorization form.

	/ /
Print Name of Patient	**Date of Birth of patient**
	/ /
Patient Signature (minors 12 and older must sign)	**Date**
	/ /
Parent or Guardian Signature	**Date**
	/ /
Witness	**Date**

NOTE: This Patient Authorization to Release Health Information expires 12 months from the signing date.

IN STEP BEHAVIORAL HEALTH - MEDICAL RECORD POLICY

The following policy is in accordance with Illinois Statues 735 ILCS 5/8-2001(d) and 735 ILCS 5/8-2001.5. The copying fees are in accordance with those published by the Illinois Comptroller's office for 2018.

- A Release of Information (ROI) must be signed by the patient or patient's legally authorized representative and validated by ISBH office staff. Such validation occurs when the form is completed in the office or, in other cases, through a follow-up phone call.
- Records will be processed within 30 days from the date the record request was received, provided the ROI signature is confirmed to be valid in a timely manner. ISBH will confirm the requestor's signature by phone or in person, whichever is most expedient. In no case will a valid request for copies of records exceed 60 days.
- Records will not be sent until the copying fee is received from either the requesting entity or the patient.
- The total cost for copying medical records in paper format is the sum of the handling fee, per page cost (indicated in the table below) and postage or shipping, if applicable.
- The handling fee will be waived for records requested on behalf of a deceased individual.
- Medical records requested in electronic format will be provided on a USB flash drive with the total cost set at 50% of the per page charge as calculated for paper records.
- There is no charge for Medical Records sent to another doctor's office.

Copying Fee Schedule for Medical Records for 2022	
Handling Fee	$31.56
Copy pages 1 through 25	$1.18/page
Copy pages 26 through 50	$0.79/page
Copy pages in excess of 50	$0.39/page