KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

AUTHORIZATION FOR BEHAVIORAL HEALTH RELEASE OF MEDICAL INFORMATION

Patient Information

First Name _____ Last Name _____ Maiden/Other Name(s) _____ _____/_____/_____ Date of Birth

Address _____ (_____)_____ Phone Number

City _____ State _____ Zip Code _____

Email Address _____

Release Information From

*Release of Medical Records **From**:*

KSB Hospital
403 E. First Street
Dixon, IL 61021

*Release of Medical Records **To**:*

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Medical Records to Be Released

By initalling the below boxes, I am directing KSB to release specific records to me or my designated representative.

Please Initial All That Apply:

- ☐ **Records regarding Mental Health Treatment**
- ☐ **Records regarding developmental disability**
- ☐ **Records regarding substance abuse treatment/referral (i.e. alcohol or drugs)**
- ☐ **Records regarding Sexual Assault**
- ☐ **Records regarding Child Abuse/Neglect**

Purpose of Release of Records _____ Provider Signature of Approval to Release _____

Authorization

Expiration: The authorization will expire one year from date of authorization, unless otherwise revoked by the patient.

I understand that I have the right to inspect and copy the information that is requested and to be released pursuant to this Authorization.

I understand that I may refuse to sign this authorization and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

Signature of Patient or Legal Representative _____ Relationship to Patient _____ Date _____
(Patients ages 12 - 17 may be required to sign and date with co-signature of parent/legal guardian)

Co-Signature _____ Relationship to Patient _____ Date _____