Park Ridge Psychological Services

AUTHORIZATION TO RELEASE MENTAL HEALTH/MEDICAL INFORMATION

I authorize Park Ridge Psychological Services to disclose, release and/or exchange information to/with the following:

Name (Examples: Healthcare Facility, Ins. Company, Self, etc.) Phone Fax

Address City State Zip Code

Regarding:

Patient Name Date of Birth

Address Phone Number

City State Zip Code

Approximate dates of service: _____ to _____

Purpose: The purpose of the use or disclosure is for:

- ☐ Treatment Planning
- ☐ Other _____

Requested Information to be disclosed:

The information to be used or disclosed by Park Ridge Psychological Services' psychologists, therapists, and other employees includes only those items checked below. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. <u>The information to be used or released includes</u>:

- ☐ Psychological Evaluations and Assessments
- ☐ Progress/Psychotherapy Notes
- ☐ Treatment Plans
- ☐ Release Forms
- ☐ Consultation Reports
- ☐ Verbal Communications Only
- ☐ Other _____

Please note if there is any information you do NOT want included in your released information (Examples: Substance Abuse Treatment, Pregnancy, Assessments):

Please note your transmission preferences:

- ☐ Mail Records (with the mailing address listed above)
- ☐ Fax Records (with the fax number listed above)
- ☐ Hold for pickup at Park Ridge Psychological Services office

This authorization is limited to that information requested above to be disclosed to or by Park Ridge Psychological Services. I hereby release Park Ridge Psychological Services from all legal responsibilities or liability that may arise from the use, disclosure or redisclosure of medical or other records and other health information in reliance on this authorization.

Once the organization or person authorized to receive this information has received it, the information may be re-released by that organization or person. If this is the case, the information may no longer be protected by federal laws; however, Illinois law does not allow the re-release of AIDS/HIV, genetic testing, or mental health and developmental disabilities information by the receivers of the information except in precise situations allowed by law. If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient.

I understand that I may refuse to sign this authorization and the result would be that the records would not be disclosed. I understand that if I do not sign this authorization, Park Ridge Psychological Services may not deny me care based on my unwillingness to sign this form. However, Park Ridge Psychological Services may refuse to provide care to me if the care being provided is solely for the purpose of collecting health information to be released to a third party.

I have the right to revoke this authorization at any time. My revocation must be in writing. Any revocation will be valid except for the release of information that occurred prior to this authorization being withdrawn.

I understand that I have the right to inspect and copy any information that will be released.

This release will expire on: _____ /_____ / 2020

By signing below, I agree to the statements in this authorization form.

/2019

Client Name/Signature of client age 12 or older — Date /2019

Witness Signature — Date

Parent/Guardian Signature — Date

Witness Signature — Date