SHARED VISION
PSYCHOLOGICAL SERVICES
Building Healthy Connections

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# Authorization for Release of Information

I,_____, hereby authorize _____
(Name) (Person to Disclose Information)

to exchange\release any and all records of information regarding _____
(Client)

**(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)**

The following must be ***checked and initialed*** to be included in the use and/or disclosure of other health information:

☐_____ Mental Health Information ☐_____ Medical Records and Information ☐_____ Treatment Notes ☐_____ Care Summary

to: _____
(Receiving Agency/Person) (Address/Contact Info)

For purposes of: (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care

☐ Billing, payment, and financial matters and arrangements

☐ Therapist transition

☐ Consultation, advice, and representation regarding my condition and needs

☐ Housing or other arrangements and services ☐ Other:_____

This consent is valid until (calendar date): _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re-disclose it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur_____

_____

_____ _____
Signature of Individual aged 12 or older Date

_____ _____
Signature of Guardian if Under 18 or Disabled Date

_____ _____
Signature of Staff Person Disclosing/Obtaining Info Date

**NOTICE TO PATIENT AND RECEIVING AGENCY:** Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

_____

**REVOCATION OF AUTHORIZATION:** The undersigned hereby revokes the above authorization for disclosure:

_____ _____
Signature of Individual aged 12 or older Date

_____ _____
Signature of Guardian if Under 18 or Disabled Date

_____ _____
Reviewed By (Staff Signature) Date