

Authorization/Release of Information

I, _____, whose Date of Birth is _____, authorize _____
Name of Patient/Client

of PeoplePsych, LLC to disclose to and/or obtain the following information from _____:
Name of Person or Title of Person or Organization

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Nursing/Medical Information | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Toxicological Reports/Drug Screens | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Educational Information | <input type="checkbox"/> Other _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization at any time by notifying _____ in writing at 111 N Wabash, No. 1203, Chicago, IL 60602. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____ . If a calendar date is not recorded to terminate permission to release, information may only be released on the date the authorization is received.

Conditions

I further understand that _____ will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by Federal and State laws.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Relationship Date

Signature of Staff Witness Attesting to Identity & Authority Date