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 check each item to be disclosed)

_____ Assessment	_____ Current Treatment Update	_____ Discharge/Transfer Summary
_____ Diagnosis	_____ Medication Management Information	_____ Continuing Care Plan
_____ Psychosocial Evaluation	_____ Presence/Participation in Treatment	_____ Progress in Treatment
_____ Psychological Evaluation	_____ Nursing/Medical Information	_____ Demographic Information
_____ Psychiatric Evaluation	_____ Toxicological Reports/Drug Screens	_____ Other_____
_____ Treatment Plan or Summary	_____ Educational Information	_____ 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 PeoplePsych LLC 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, this authorization expires one year after date signed.

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