

# Consent for the Release Of Information

<b>A. PATIENT INFORMATION</b>			
Patient Name			
Address (Last)		(First)	(Middle Initial)
(Street)		(City)	(State) (Zip)
Patient ID#:	Date of Birth:	Telephone Number:	
<b>B. PROVIDER INFORMATION</b>		<b>C. INTENDED RECIPIENT OF RECORDS</b>	
Provider Name		Name	
(Last) (First) (Initial)		(Last) (First) (Initial)	
Office Address		Location Address	
(Street) (City) (State) (Zip)		(Street) (City) (State) (Zip)	
Provider Telephone Number:		Telephone Number:	
<b>D. PATIENT BEHAVIORAL HEALTH INFORMATION</b>			
Date of Initial Assessment		Diagnosis	
Summary of Patient Evaluation			
Current Symptoms			
Current Medications/Treatment Plan			
<p>The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning patient. The purpose of such release is to allow for coordination of care, which enhances quality, and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.</p>			
<input type="checkbox"/> Information contained on this form <input type="checkbox"/> Current Medication/Treatment Plans <input type="checkbox"/> Substance Dependence Assessments <input type="checkbox"/> Other (Describe)		<input type="checkbox"/> Assessment/Evaluation Report <input type="checkbox"/> Discharge Reports/Summaries <input type="checkbox"/> Laboratory/Diagnostic Test Results <input type="checkbox"/> Medical history	
<p>This consent to release information shall expire, unless otherwise provided by state law.</p> <input type="checkbox"/> 12 months from date of signature <input type="checkbox"/> 60 days after termination of treatment (not valid in IL) <input type="checkbox"/> other calendar date _____			
Signature of Patient/Legal Guardian	Relationship to Patient (if applicable)		Date
X			
Signature of Minor Patient			Date
X			
Signature of Witness			Date
X			

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at anytime, except to the extent that action has already been taken in reliance upon it, by giving written notice to the parties above.