Release of Information Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist _____ to release _____
_____
_____ (provide description of the information that you want disclosed – your description should be as specific and detailed as possible)

This information should only be released to (name and address of person to whom the information is to be released) _____
_____

I am requesting my psychologist to release this information for the following reasons ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose) _____
_____

This authorization shall remain in effect until (fill in the expiration date)(if no calendar date is stated information may be released only on the day the authorization form is received by the psychologist) _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

_____ _____
Signature of patient Date