MENTAL HEALTH RECORDS: AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

PATIENT INFORMATION

Patient's Name: _____ Birthdate:_____

Street Address: _____ SS#:_____

City, State, Zip: _____ _____

Maiden/Other Names:_____ Phone#: _____

I authorize the use/disclosure of my mental health records and/or information as follows:

2. Party who has my Mental Health Records (who is sending my records)

❑ The Rock Counseling Group
201 West Springfield Ave, Suite 605 Champaign, IL 61822

❑ Other entity Name:_____

Address:_____

Party or Parties Who I want to receive my Mental Health Records (who will get my information)

❑ The Rock Counseling Group
201 West Springfield Ave, Suite 605 Champaign, IL 61822 Fax 217-501-4322

❑ Other entity Name:_____

Address:_____ Fax #_____

Purpose of Use/Disclosure of My Mental Health Records and/or Information

❑ Medical follow-up ❑ Employment reasons ❑ insurance ❑ Lawsuit ❑ Patient request (I do not wish to be more specific.) ❑ Coordination of Care

The Dates of Records and/or Information to be used or disclosed:

❑ **Records or information from: _____ to _____**
[Beginning Date] [End Date]

Description of My Mental Health Records and/or Information to be used and Disclosed

❑ Hospital Consult-Psychology/Psychiatry ❑ Office Visit-Psychology/Psychiatry

❑ Office Visit-Neuro Psychiatry ❑ Testing Data-Psychology/Psychiatry, Neuropsychology

❑Hospital Progress Notes-Psychology/Psychiatry ❑ Labs ❑ Other:_____

Protected records (check and initial the following)

_____❑ Alcohol/drug abuse treatment records
_____❑ Genetics
_____❑ HIV

Expiration this authorization will expire one (1) year from the date I sign it. If I want it to expire on a different date, then that date is: _____

Canceling this Authorization: I may cancel this authorization before it expires by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to The Rock Counseling Group at the address shown at the bottom of this page. The cancellation will take effect when The Rock Counseling Group receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before The Rock Counseling Group received my letter.

Re-disclosure of My Health Records and/or Information: I understand that the person who receives my mental health information, alcohol and drug abuse records or HIV records may NOT disclose it to someone else without my permission, unless permitted by law.

Effect of Not Signing this Authorization: I am not required to sign this authorization in order to receive most health care services at The Rock Counseling Group. However, I understand that if the ONLY reason I am seeing a Rock Counseling Group provider is to create health information for someone else's use (such as my employer or for legal proceedings), The Rock Counseling Group may refuse to see me if I do not sign this authorization.

My authorization:

_____ _____
[Signature of Patient] [12 years old and over] [Date Signed]

_____ _____
[Signature of Legal Representative or Guardian] [Date Signed]

_____
[Printed name of Representative or Guardian]

[Relationship to Patient (authority to sign for patient)] _____

_____ _____
[Signature of Witness to Patient's signature] [Date Signed