PATIENT CONSENT TO RELEASE INFORMATION

Patient Name: ______________________________

Address: ______________________________

Phone: ______________________________

Date of Birth: ______________________________

I hereby authorize: ______________________________

To use or disclose to (name): ______________________________

(Address): ______________________________

(Phone): ____________________ **(Fax):** ____________________

(E-mail): ______________________________

☐ **Two Way Release** ☐ **One Way Release**

Description of the specific information to be used or disclosed:

☐ Treatment Summary ☐ School functioning

☐ Psychological testing/evaluation ☐ Medical

☐ Psychological history ☐ Other ______________________________

The information is being requested for the following purpose(s):

☐ Treatment Planning ☐ Coordination of ancillary services

☐ Follow-up care ☐ Evaluation

☐ Other (specify) ______________________________

This authorization shall remain in effect from the date signed below until ____________________ (expiration date or event).

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (expect to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research related treatment.

Patient Signature: ______________________________
(age 12 or older)

Parent Signature: ______________________________

2530 Crawford Avenue ■ Office 115/Studio 302 ■ Evanston, IL 60201 ■ **(847) 337-2337**