6040 State Route 53, Suite B, Lisle, IL 60532
Phone 630-524-4000 Fax 630-524-2311

Authorization for Release of Confidential Health Information

I, _____ Date of Birth: _____
Insert Name of Patient or Authorized Agent

authorize CORE Connection Counseling to disclose to and/or obtain from:

_____
[Insert Name of Person or Organization]

the following information for _____
(Patient's name)

Description of Information to be disclosed (please initial)

_____ Assessment/Diagnosis
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Medication Management Information
_____ Treatment Plan or Summary
_____ Educational Information/Evaluations
_____ Discharge/Transfer Summary
_____Account information
_____Verbal discussion
_____ 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 or at the request

Of the individual _____For Payment of Account _____ or other _____.

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to Disclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid for 365 days or until dated below.
I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so.
I also understand that I will not be able to revoke this authorization in cases where the provider has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.
(Date)

_____
Signature of Patient/Client/Parent/Guardian Date
Patient signature is required in addition to the parent or guardian signature for patients ages 12-17

_____
Signature of Witness Date