Collaborative
Counseling & Psychiatry

Release of Information Form

I, _____ , Date of Birth: _____ , hereby authorize Collaborative Counseling & Psychiatry to share my personal healthcare information from the dates of _____ to_____as follows:

Disclose To (share information with)

Name of Agency/Institution/Individual		
Address	Phone	Fax

Obtain From (receive information from)

Name of Agency/Institution/Individual		
Address	Phone	Fax

The following specific information may be shared:

☐	Medical Records
☐	Entire Treatment Record
☐	Psychological Testing Reports
☐	Psychiatric Records
☐	School Records (IEP, evaluations, & reports; records of academic & behavioral functioning)
☐	Labs/Diagnostics/Imaging
☐	Medication List
☐	Other (Specify)

This request is for the purpose of:

☐	Treatment Planning	☐	Utilization review/Case management
☐	Coordination of care	☐	Response to request
☐	Personal Use	☐	Other (Specify)

My signature below indicates I understand the following:

This consent can be revoked at any time by submitting a written and dated notice of revocation. Collaborative Counseling & Psychiatry or any of its employees cannot be held liable for any disclosures authorized by this release which occurred prior to the date of revocation. Unless revoked by written notice, this authorization for release of information is valid and binding for **one year** from the date signed. Collaborative Counseling & Psychiatry is not responsible or liable for others' use of disclosed/released information. The Illinois Mental Health and Developmental Disabilities Confidentiality Act, stipulates that communications and records may be re-disclosed only if the person(s) who authorized this disclosure specifically authorizes such re-disclosure.

_____ _____ _____ _____

Signature of Patient Date Signature of Parent/Guardian Date

_____ _____

Witnessed by Date

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