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AUTHORIZATION TO RELEASE PROTECTED INFORMATION FROM YOUR CLINICAL RECORD TO THE PERSON YOU DESIGNATE

I authorize____(*Facility/Therapist's Name*) to release (*specific nature of information to be released*): ____

about (*Recipient's Name*): ____

to (*Receiving Agency/Person's Name and Address*):

____

____

The information requested above is being released for the purpose of

____

This consent is valid until: ________/________/________
Month Day Year

The statues that govern this Authorization include but are not limited to:

Mental Health and Developmental Disabilities Confidentiality Act (740ILCS110), 735ILCS5/8-2001 (inspection and copying of hospital records), and any relevant confidentially code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

I understand that I have the right to copy and inspect the information being disclosed. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this 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 mental health practitioner generally may not condition mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above, the following are the consequences (or indicate "none"): ____

X____ Date: ____________________
(Recipient Age 12 or over)

X____ Date: ____________________
(Parent/Guardian of minor or guardian of a legally disabled recipient)

If the signature is not the Recipient's, indicate the legal relationship to the recipient and the legal basis on which consent

is given for the recipient:____

X____ Date: ____________________
(Witness)

Notice to Receiving Agency/Facility/Person: Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (740 ILCS 110/1 *et.seq.*) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorizations for such redisclosure.