cbt
chicago

Authorization for Release of Mental Health Information

Patient's Name:		Date of Birth:	
Parent/Guardian Name:		Relationship to Patient:	

I request and authorize _____ to **release** his/her entire chart and file including any and all medical records, mental health records and communications, psychotherapy notes, and/or a summary of the treatment of the patient named above to:

Name: _____

Phone Number: _____

Fax Number: _____

Office Location: _____

☐ Can also **obtain** charts and files from person listed above

This authorization is limited to the following specific types of information:

☐ All mental health information

☐ Other: _____

Information is being released for the purpose of:

☐ Treatment coordination/planning

☐ Other: _____

_____ I understand that I may revoke this consent at any time, and that I have the right to inspect and copy the information to be disclosed.

This consent is valid until: _____

_____ It has been explained to me that my refusal to consent to this release of authorization will result in the following: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

Patient Signature:		Date:	
Parent/Guardian Signature:		Date:	
Parent/Guardian Signature:		Date:	
Witness Signature:		Date:	

NOTICE TO RECEIVING AGENCY/ PERSON: Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such a redisclosure. Under the 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 authorization of such redisclosure.