AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

FROM YOUR CLINICAL RECORD TO THE PERSON/ORGANIZATION YOU DESIGNATE

I, _____, DOB_____,

Authorize Carolyn Nowakowski, Psy.D. to exchange information with:

Name/Organization:_____ Phone Number:_____

Address:_____ Fax Number:_____

Specific nature of information to be released:

_____any or all of the following
_____attendance/scheduling/transportation
_____information related to payment
_____presenting complaints/issues
_____diagnosis and/or assessment results
_____treatment plan and goals
_____summary of treatment
_____response to treatment/progress
_____prognosis
_____recommendations/suggestions
_____substance use/abuse information_____initial
_____other:_____

The information above is being released for the purpose of:

_____facilitating consultation and/or collaboration
_____facilitating continuity of treatment
_____facilitating scheduling/transportation
_____facilitating payment
_____facilitating family involvement in treatment
_____other:_____

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here:_____
2. I have the right to copy and inspect the information being disclosed.
3. 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.
4. The statues that govern this authorization include but are not limited to: Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/8/2001 (inspection and copying of hospital records), and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.
5. If I refuse to consent to the release of information specified above, the following are the consequences:
   _____
   My psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____
Client (Adult or Minor over age 12) Date

_____ _____
Parent/Guardian of minor or legally disabled client/patient (if applicable) Date

_____ _____
Witness Date

If the signature is not the client's, indicate the legal relationship of the signer to the client and the legal basis on which the consent is given for the client:_____

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 re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. 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 the client's specific authorization for such disclosure.

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