Consent for Release of Information

I, ____, authorize Chicago Clinical Associates to _____ (**send**) _____ (**receive**) protected health information to/from the following individual:

Name: ____

Address: ____

Phone Number: __________________________ Fax Number: _____________________________

I am requesting the release of this information for the following purposes: ___________________

____

[If you do not desire to state a specific purpose, you may write "At the request of the individual"]

This authorization shall remain in effect until ____

I understand that I have the right to revoke this authorization at any time through written notice sent to the office address of the facility providing the information. I understand that my revocation will not be effective to the extent that the facility has already taken action in reliance upon 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 Chicago Clinical Associates or the facility providing the information, generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the sole purpose of creating health information for a third party.

I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

_______________________________ _______________________________

Client Signature *Witness Signature*

________________ ________________

Date *Date*

If this authorization is signed by a personal representative of the client, a description of such representative's authority to act on behalf of the client must be provided: ____________________

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