Geiger Clinic of Psychiatric Care
1752 Windsor Road, Suite 203
Loves Park, IL 61111
815.986.1113 (P) 815.986.1119 (F)

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION TO BE: _____Released _____Requested _____Shared

PATIENT NAME: (PRINT) _____ DOB: _____

Where to send your medical information TO or RECEIVE from:

Company Name/Physician Name: _____

Address/Phone Number: _____

Description of Information to be Disclosed

__ Diagnosis/Assessment
__ Current Treatment Update
__ Treatment Plan
__ Medication Management Information
__ Psychiatric Evaluation
__ Continuing Care Plan
__ Discharge/Transfer Summary
__ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. These records may contain mental health, developmental disability, alcohol and drug abuse, or sexually transmitted disease information. Only records believed necessary for the stated purpose shall be released. I may inspect and obtain photocopies of the records disclosed. Photocopies of this authorization will be considered as valid as the original.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my provider at Geiger Clinic of Psychiatric Care. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____If a calendar date is not stated, information may only be released on the date the authorization is received.

Conditions

I further understand that Geiger Clinic of Psychiatric Care will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et.seq.) I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____

Signature of Parent/Client **Date**

_____

Signature of Parent/Client **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). Clients 12 and over **must** also sign the release for it to be valid.

_____ Check here if patient/client refuses to sign authorization

_____

Signature of Witness attesting to Identity and Authority **Date**