



A Division of the Center for Rural Psychology
P.O. Box 8071, Elburn IL 60119
T:630/365-0899 F:630/365-9150

AUTHORIZATION TO RELEASE INFORMATION

This form when completed and signed by you, authorizes me to receive information from and release protected information from your clinical record to the person you designate.

I authorize my psychologist/counselor, _____ and/or his or her administrative and clinical staff to release and/or receive _____

This information should only be released to or received from: Name _____

Address _____ Phone _____

I am requesting my psychologist/counselor to release/receive this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ (fill in expiration date) (if no calendar date is stated, information may be released only on the day the authorization form is received by the psychologist).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 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.

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

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

X _____
Signature of Patient (age 12 or over) Date
or representative*

X _____
Signature of Witness Date

*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Notice to receiving agency/person: Under Illinois and federal law you may not redisclose any of this information unless specifically authorized by above responsible party