



1752 Windsor Rd., Ste. 203, Loves Park, IL 61111 Phone: (815) 986-1113 Fax: (815) 986-1119

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ DOB: _____

Current Address _____

I HEREBY AUTHORIZE AND REQUEST CLINIC OF PSYCHIATRIC CARE, MARIANNE GEIGER, M.D. _____, AND STAFF, 1752 WINDSOR ROAD, SUITE 203, LOVES PARK, IL 61111, (815) 986-1113

___ **TO RELEASE TO** AND/OR ___ **GET INFORMATION FROM (Person or Facility)**

NAME _____ PHONE: _____

ADDRESS _____ FAX: _____

TO RELEASE, USE AND/OR DISCLOSE FOLLOWING HEALTH INFORMATION:

___ ENTIRE MEDICAL RECORDS

___ ABSTRACT OF ABOVE ONLY (includes summary letters)

___ OTHER (specify) _____

RELATING TO THE FOLLOWING TREATMENT TIME PERIOD:

From _____ to _____ (dates)

THE PURPOSE(S) OR NEED FOR THIS DISCLOSURE IS:

___ MEDICAL CARE ___ EVALUATION ___ PROGRESS ___ HISTORY (MEDICAL)

___ SCHOOL SERVICES ___ COURT REFERRAL

EXPIRATION: This authorization must be received within 90 days of the date of signature, and will expire one year from the date of authorization, unless otherwise revoked by patient.

PLEASE READ AND FOLLOW CAREFULLY:

I understand that I may revoke this Authorization in writing at anytime, except to the extent information was released or other action taken in reliance on it, or if obtained as a condition of insurance coverage and the insurer has legal right to contest a claim or policy. Any written revocation must be signed by the patient or legal representative, and delivered to the Clinic of Psychiatric Care.

I understand that the above identified health information may contain mental health, developmental disabilities, alcohol or drug use, and/or HIV (AIDS) test results and /or information, and I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

I understand that I may refuse to sign this Authorization, and represent that no person has coerced or imposed and inappropriate conditions on my providing this Authorization. No other adverse consequences to me will result if I refuse to sign this Authorization.

I understand that this Authorization shall expire, without my express revocation, one year following the date of signature unless otherwise indicated. I further understand that my health information and hard copy of this Authorization will be kept in my records which can be accessed by my health care provider, medical support personnel and other health care providers who are authorized to participate in my care. I understand that I am authorizing the aforementioned information released orally, through copies of medical records or by fax.

I hereby release and hold harmless The Clinic of Psychiatric Care, their staff providers, employees, agents and attorneys, from and against and all liability, damages, claims, or suits, including reasonable attorney fees, in connection with the disclosure or use the information as identified above.

Signature of Patient or Legal Representative Date

Co-Signature Date

Signature of Witness Date