CENTER FOR PSYCHOLOGY AND WELLNESS
FACILITATING BALANCED FUNCTIONING AND POSITIVE WELL-BEING

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

CPW may coordinate treatment when appropriate with your physician(s) or other professionals in order to create continuity of care. Below is a release of information giving CPW your permission to discuss your care with those you specify.

I, **_____(name of patient),** authorize that the protected mental health information regarding the patient be released:

FROM: _____Center for Psychology and Wellness _____, In clinical practice at the Center for Psychology and Wellness, P.C.,
(individual or institution name)

TO: _____
(receiving agency/person's name *and* address)

The information requested above is being released for the purpose of ("at the request of the individual" is all that is required if you are a CPW patient and you do not desire to state the specific purpose):_____

☐ ***Check here*** ***if you also authorize the release of mental health information reciprocally from the named recipient to the Center for Psychology and Wellness, P.C.***

This consent is valid from: _____ This consent is valid until: _____

Disclosure will include (check the boxes below):

☐ Inpatient and/or outpatient treatment records for physical, psychological, psychiatric, emotional illness.
☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnosis, prognoses, recommendations, or testing records, and behavioral observations, checklists completed by any staff member or the patient, or similar documents.
☐ Social, emotional, educational and vocational histories/records for client and family
☐ Social work assessments and plans
☐ Drug and/or alcohol abuse/dependency information contained in these records will be released under this authorization unless indicated
☐ HIV-related information contained in these records will be released under this authorization unless indicated

The statutes that govern this Authorization include but are not limited to: The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/8 2001 (inspection and copy of hospital records), and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

I understand that I have the right to copy and inspect the information being disclosed. 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 authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that my provider generally may not condition psychotherapeutic services upon my signing an authorization unless the psychotherapeutic services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above, there are no consequences.

X_____(Patient, age 12 or over) Date: _____
X_____ Date: _____
(Parent/Guardian of minor or guardian of a legally disabled recipient)
If the signature is not the Recipient's, indicate the legal relationship to the recipient and the legal basis on which consent is given for the recipient: _____
X_____(Witness) Date: _____

Notice to Receiving Agency/Facility/Purpose: Under the provision of the Illinois Mental Health Developmental Disabilities Confidentiality Act, (740 ILCS 110/1 et.seq.) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such record, nor information from such records may be further disclosed without specific authorization for such redisclosure.