PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

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NORTHBROOK, IL, 60062
847.686.0090 Phone or Fax

Permission for Release/Request of Confidential Information

To: _____
Name of healthcare provider/physician/facility/individual

_____
Street address, City, State, Zip

Re: _____ _____
Patient name Date of birth

I, _____(name of patient/guardian), hereby authorize Primary Care Psychology Associates, LLC and _____(name of provider/facility/individual) to exchange information.

The type of information to be disclosed:
□All records □Evaluations □Medical Records □ Diagnosis □Treatment Plan □Psychological/Medical Test Results □ Mental Health □Record Summary □Course of Treatment □ Psychotherapy Notes □Other _____

Exceptions:_____

The purpose of such disclosure:
□Ongoing Treatment □Medical Care □ Consultation □ Evaluation □ Transfer □ Legal issues □ Coordination of Care □Health Benefit Utilization □ Other _____

Dates of records requested:_____

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated within this form from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization with certain exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. I also understand that a fee may be associated with the release of my records, and that my records may not be released until I, or the responsible party, pay the fee. Furthermore, I recognize that my records may not be released if I have an outstanding balance with Primary Care Psychology Associates and until the balance is paid. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Patient/Guardian signature Date

_____ _____
Patient 12-17 years old signature Date

_____ _____
Clinician/Witness Signature Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.