PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

400 SKOKIE BLVD, SUITE 245
NORTHBROOK, IL, 60062
847.686.0090 Phone or Fax

Permission for Release/Request of Confidential Information

_____

Name of entity authorized to exchange information with Primary Care Psychology Associates, LLC on behalf of patient

_____

Street address, City, State, Zip Phone Fax

Re: _____ _____

Patient name Date of birth

I, _____(**name of patient/guardian**), hereby authorize Primary Care Psychology Associates, LLC (PCPA) and _____ **(entity authorized to exchange records with PCPA)** to exchange information on my behalf and this exchange to be documented in my patient medical record.

The type of information to be exchanged between PCPA and entity listed above on patient's behalf:

☐ All relevant information ☐ Medical Records only ☐ Psychotherapy Notes only
☐ Psychological/Medical Test Results ☐ Mental Health Record Summary
☐ Other _____
Exceptions:_____

The purpose of such disclosure: Coordination of Care
Dates of records requested: First appointment to present

This consent is in effect for one year from the date signed below. 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

_____ _____

Clinician/Witness Signature Date

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