PREMIER PSYCHIATRY
PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

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Chicago Ridge, IL 60415

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PATIENT AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____ Date of Birth: ___/____/____

SELECT FROM THE FOLLOWING OPTIONS BELOW:

☐ I authorize the release of medical information **FROM Premier Psychiatry**
☐ I authorize to release medical information **TO Premier Psychiatry**

RELEASE APPLIES TO INDIVIDUAL OR CORPORATION:

Name: _____

Address: _____

City: _____State: ____ ZIP Code: _____

Phone #: (_____) _____ Fax #: (_____) _____

☐ My entire Medical records pertaining to my mental health **including** therapy notes.
☐ My entire Medical records pertaining to mental Health **excluding** therapy notes.

From Date of service ___/____/____ to ___/____/____

PURPOSE:

□ Personal Records □ Continue Care □ Legal □ Insurance □ Medications □ Progress in Treatment □ Diagnosis
□ Alcohol and Drug Evaluation □ Background Information □ Recommendations □ Other (specify) _____

- I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed, as described above, may no longer be protected by these laws and may be re-disclosed.
- I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment, or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.
- I understand that I have the right to inspect or copy any of the information disclosed by this authorization.
- I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that **Premier Psychiatry** has already acted in reliance upon this authorization as shown by my signature below and as explained in the Notice of Privacy Practices.
- I understand that **Premier Psychiatry**, and its employees are released from any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.
- I understand that I may request a copy of this signed authorization form.

_____ ___/____/____
Print Name of Patient **Date of Birth of patient**

_____ ___/____/____
Patient Signature (minors 12 and older must sign) **Today's Date**

_____ ___/____/____
Parent or Guardian Signature **Today's Date**

_____ ___/____/____
Witness **Today's Date**

NOTE: