PREMIER PSYCHIATRY
PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

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Willowbrook, IL 60527

P: 708-799-8384
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Consent to Exchange Information

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities below to release verbally or in writing information regarding my mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and State laws governing the continentality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider received the request. This consent can be revoked by written statement any time unless action based on it has already begun.

Premier Psychiatry is authorized to release protected health information related to the evaluation and treatment of

_____ _____ / _____ / _____

Patient Name Date of Birth

I give consent for information regarding my treatment/care to be shared with:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

_____ I do not wish to have information regarding my treatment with this practice released.

My signature below represents that I have read and understand the terms and statements above.

X_____ _____ / _____ / ____

(If signed by a guardian or legal representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)