PSYCHWISE SERVICES
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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE AND OTHER PERSONAL HEALTH INFORMATION

I ______________________________________, hearby authorize ____
Patient/ Parent/ Guardian/ Power of attorney — Psychotherapist

to release any and all records or information regarding ____________________________________DOB____/____/____
Name of Patient

____
Nature of specific Information to be disclosed

The following items must be **checked and initialed** to be included in the use and /or disclosure of other health information:

❑ ____ HIV / AIDS related treatment ❑ ____ Mental Health Information ❑ ____ Psychotherapy Notes

❑ ____ Sexually Transmitted Diseases ❑ ____ Drug / alcohol diagnosis, treatment referral

TO____
Name of Person and / or Receiving Agency

____
Street Address — City — Zip code

____
Phone — Fax

For the purpose: (check all that apply)

❑ Continuing (health and mental health treatment or care and continuity of care

❑ Billing ,payment, and financial matters and arrangements

❑ Therapist Transition

❑ Consultation, advise and representation regarding my conditions and needs

❑ Housing, other arrangements, and services

❑ Other ____

This consent is valid until (calendar date) __________ /_________/________
I understand that I have the right to inspect and have copied the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written consent.

I also understand that if I refuse to consent to this release of information the following may occur

____

________________________________ ________________________________ ____/_____/______
(Minor Recipient 12 -17yr old Inclusive) (Adult Patient or Parent) Date

____
Witness

<u>Notice to the patient and receiving agency</u>** : Under the provision of the IL Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Act, there may not be rediscloser of any of the information provided pursuant to this release unless the patient and/or parent of the patient who is a minor, specifically authorizes such disclosures. A separate release is required for psychotherapy notes.

8/2015