AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete this form if you would like me to coordinate care with other treatment providers, or release information to third parties for other purposes. Please let me know about any questions.

*Name of Patient:*_____ *Date of Birth:*_____

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

FROM:		**TO:**	
Name:	JOEL D. CARNAZZO, PSYD	Name	
Address:	550 FOX GLEN CT	Address:	
	BARRINGTON, IL 60010		
Telephone:	(847) 381-5001	Telephone:	
Fax:	(847) 381-5059	Fax:	

The type of information to be used or disclosed is as follows *(check all that apply)*:

- ☐ Record for Dates of Service
- ☐ Entire Mental Health Record
- ☐ Billing Statements
- ☐ Discharge Summary
- ☐ Therapy Notes
- ☐ Consultations
- ☐ Other *(please specify)*_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services even though I am protected by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2, the Illinois AIDS Confidentiality Act, or the Mental Health and Developmental Disabilities Confidentiality Act. A request in writing must be made to exclude the above from the disclosed information.

The purpose for which this disclosure is being made is (check all that apply):

- ☐ Sharing with other healthcare providers
- ☐ My personal records
- ☐ Other *(please describe)* _____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. In accordance with the Mental Health Code – No person or agency to whom any information is disclosed may redisclose such information unless the person who consented to the disclosure specifically consents to such redisclosure. I understand that I have the right to inspect and copy the information that is to be disclosed.

This Authorization expires on: _____ / _____ / _____. If I fail to specify an expiration date, this authorization will expire six months from date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information.

_____ _____ _____ _____

Witness *Date* *Signature of Patient or Legal Representative* *Date*

This Authorization must be signed by the patient or guardian if patient is less than 12. In keeping with the Mental Health & Services Disability Confidentiality Act, if the patient is a minor and recipient is 12 years of age or older, then this authorization must be signed by the patient. If the patient is mentally incompetent and over the age of 18, this Authorization must be signed by the appointed legal representative of the patient.