Portrait Health Centers™

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

NOTICE RELATED TO ALCOHOL AND/OR DRUG TREATMENT: For the recipient of the information: information regarding alcohol or drug abuse treatment is protected by Federal confidentiality rules. If any of the requested records contain such information, the Federal law prohibits you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the patient or legal guardian. A general authorization for the use or release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: PHC of Buffalo Grove Clinical Psychology/Portrait Health Centers

To obtain or release health information and records obtained during the course of care of:

Patient Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Patient's Phone: ______________________________

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1. Information can be: (circle) requested from and/or sent to the following persons or organizations.

   Person/Organization Name: ____

   Address: ____

   Phone/Fax: ____

2. Purpose: The purpose of this request or disclosure is: ______________________________

3. Information to be used or disclosed:

The information requested or disclosed includes only those items checked below. I understand that this authorization extends to all or part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS tests results or diagnoses. The information to be requested or released includes:

____No Restrictions; all information is permitted to be requested or disclosed

____History and Physical Exam	____Psychiatric Evaluation	____ Psychological Testing
____Laboratory Data	____Education Information	____Medication Records
____Assessments	____Treatment Plans	____Progress Notes
____Medical Diagnoses	____Family Issues	____Drug/Alcohol Issues
____Consultation Reports	____Treatment Progress	____Psychiatric Diagnoses

____Verbal Communication with: ____
____Other: ____
____Specific Restriction: ____

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Patient's Name___________________________ Release to/from: ______________________________

This authorization is limited to only that information that I have requested above to be requested or disclosed to the persons/organizations herein. I hereby release Portrait Health Centers from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If a patient is a minor, relevant state law should be followed with respect to the required signature. Portrait Health Centers will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire in 180 days, or according to the relevant state law, from the date this authorization is signed.
2. Re-disclosure: I understand that information obtained or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
3. Refusal to Sign: I understand that I may refuse to sign this authorization and that Portrait Health Centers will not condition treatment on whether I sign this authorization. The consequences, on my treatment, of my choosing not to sign have been explained to me.
4. Certification: I certify that I am (check whichever applies):
   ____The patient, and the identification I have provided is true and correct
   ____The patient's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the patient is that of: "__________________."
5. Revocation: I have the right to stop the request or release of information at any time, although I understand that I cannot do anything about information that has already been obtained or released.
6. Copy: I understand that I can receive a copy of this completed form, upon request.
7. Inspect and Copy: I fully understand that I have the right to inspect and copy the information to be disclosed.

_____________ ____

(Date) (Patient Signature)

_____________ ____

(Date) (Parent or Guardian, if applicable)

_____________ ____

(Date) (Staff Member/Witness Signature) (Printed Last Name)

Mail Form to:
Portrait Health Centers
Attn: Patient Services
175 E Hawthorn Parkway, Suite 235
Vernon Hills, IL 60061