AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Date _____ Patient's Name _____ DOB_____

I hereby authorize: PREMIER PSYCHIATRY
Psychiatric and Behavioral Health Services
10745 165th Street, Orland Park, IL 60467
Phone: (708) 799-8384
Fax: (708) 799-1305

☐ To Provide Protected Health Information To ☐ To Receive Protected Health Information From:

Information ***WILL NOT be sent without an address/phone/or fax number left below***

Name:_____

Address:_____

Phone #: _____Fax #: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED: Description must identify the information in a specific meaningful fashion. Please mark the appropriate boxes.

☐ Psychiatric Evaluation ☐ Progress Notes ☐ Psychological Evaluation

☐ Therapy Progress Notes ☐ List of Medications ☐ Substance Abuse Evaluation

☐ Verbal Communication ☐ Entire Record ☐ Other- _____

PURPOSE OF THE DISCLOSURE: Specific description of each purpose of the use or disclosure. When the individual makes the request and does not provide a purpose, the statement "at the request of the individual" is sufficient.

_____

EXPIRATION DATE: I understand that this authorization is effective for one year from the original signed date.

REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization at any time by providing written notification to the above organization. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

FEES: I understand that I will pay a fee of $0.75 per page.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____
Relationship to Patient

Revised 5/2017