AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name_____DOB_____ hereby authorize the release of the following protected health information:

( ) Psychological treatment records
( ) Medical treatment records
( ) Test/evaluation results, data, or reports
( ) Hospital records
( ) School records
( ) Other:_____

To / From

Braden Counseling Center
1815 Mediterranean Dr.
Sycamore, IL 60178
Phone: 815/787-9000
Fax: 815/787-9015

To / From

_____
Name
_____
Address
_____
City/State/Zip
_____
Phone Fax

For the purpose of continuity of care. Relationship_____

The information may be provided in written, verbal or electronic format (including e-mail and facsimile). This authorization will expire two years from date of signature. The individual may inspect or copy the health information disclosed. **Expires** _____.

I understand and agree that I have the right to refuse to sign this authorization. I do not have to sign this authorization in order to continue to receive services (except for research-related treatment and certain Court-ordered or employment related evaluations). When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law. I have the right to revoke this authorization except to the extent that PHI has already been disclosed in the reliance on this authorization. My revocation must be submitted IN WRITING to the Privacy Officer.

My signature, below, means that I understand and agree with the above statement.

_____

Client Signature Date Witness Signature Date

Relationship to individual about whom information is being disclosed:
( ) Self ( ) Parent ( ) Legal Representative

I REQUEST THAT THIS AUTHORIZATION TO DISCLOSE INFORMATION BE REVOKED

_____

Client Signature Date Witness Signature Date