AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____ **Date of Birth**: _____
Social Security Number: _____ **Home Telephone**: _____
Address: _____
(Street) (City/State) (Zip Code)

I authorize the use and disclosure of the individually identifiable health information about me that is described below by Educational & Psychological Services, Ltd. for the specific purposes listed below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below.

Specific information to be used or disclosed (check applicable box/es)

☐ Progress Notes
☐ Psychiatric Assessments
☐ Letter to my Physician
☐ Other: _____
_____
☐ Psychological Evaluation
☐ Treatment Summary
☐ Initial Evaluation

Approximate dates of Treatment: _____ to _____

Facility using or disclosing the information:
Educational & Psychological Services, Ltd.

Purpose/s of the use or disclosure:
☐ Continuation/Coordination of Care
☐ Insurance Company
☐ Other (describe) _____
_____
_____
☐ Personal
☐ Legal

Person/s or organizations/s receiving the information:
Name: _____
Address: _____
_____
Telephone Number: (_____) _____-_____

I understand the following:

- My decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and I may refuse to sign this form. If this authorization relates to the use or disclosure of mental health information, these are the consequences of my refusal to consent: _____.

- Educational & Psychological Services, Ltd. may not and will not condition mental health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits, upon my signing this authorization for the requested use and disclosure.

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- Unless specifically restricted or limited, the protected health information used or disclosed may include information related to behavioral and mental health services and evaluation and treatment for alcohol or drug abuse. * If the person or organization to which this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In that case, the person or organization receiving it may redisclose the information.

- I may revoke this authorization at any time, by presenting my written revocation to Educational & Psychological Services, Ltd. However, my revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law.

- This authorization expires on (specify date) _____. For mental health records, if no date is specified, this authorization is effective only on the date signed. For all other records, if no expiration date is specified this authorization shall be effective for 90 days after the date of my signing below, unless revoked by me sooner, or limited or restricted to a shorter time by applicable law.

- I am entitled to inspect and copy any information that is used or disclosed based upon this authorization. I am also entitled to a copy of this authorization after signing below.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
If not Patient, then Relationship of Legally Authorized Representative to Patient

_____ _____
Signature of Witness Date

*Notice to Recipients of Alcohol & Drug Abuse Information: The confidentiality of alcohol and drug abuse patient records maintained by Educational & Psychological Services, Ltd. and disclosed to you pursuant to this authorization, is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.