Pica & Associates
Psychological Services
and
Holistic Medicine

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I,_____, hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to release any and all records or information regarding_____
(Name of Patient)

_____
(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ _____ HIV / AIDS related treatment ☐ _____ Mental health information ☐ _____ Psychotherapy notes

☐ _____ Sexually transmitted diseases ☐ _____ Drug/alcohol diagnosis, treatment/referral.

to _____
(Receiving Agency/person) (Address)

For the purpose of: (please check all that apply)

☐ Continuing (health and mental health) treatment or care and continuity of care

☐ Therapist transition

☐ Housing and other arrangements and services

☐ Billing, payment and financial matters and arrangements

☐ Consultation, advise and representation regarding my condition and needs

☐ Other _____

_____

This consent is valid until **(calendar date)** _____
I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____

_____

_____ _____ _____
(Minor recipient, 12-17 yrs. Inclusive) **(Signature of adult patient or parent)** (Date)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

_____

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____ _____
(Patient, parent, guardian) (Witness)

_____ _____
(Authorized agent - Power of attorney attached) (Date)