The Prairie Clinic

1541 East Fabyan Parkway
Suite 101
Geneva, IL 60134
(630)845 9644
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AUTHORIZATION TO RELEASE INFORMATION

I, (**name of patient**)_______________________________________, (hereinafter "Patient)

hereby authorize (**name of psychotherapist**)_____________________________________,

(hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patent, but not limited to, therapist's diagnosis of Patient,

to:____

____.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 1541 East Fabyan Parkay, suite 101, Geneva, IL 60134 to be effective.

This disclosure of information and records authorized by Patient is required for the following

purpose:____.

The specific uses and limitations of the types of information to be discussed are as

follows:____

____.

Such disclosure shall be limited to the following specific types of information:

____

____.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable law may protect such information.

This authorization shall remain valid until:_______________________________________.

Patient's signature:________________________________ Date:____________________.

Parent (when applicable):___________________________ Date:____________________.