AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR ALCOHOL AND DRUG ABUSE INFORMATION

Name of Patient: _____ DOB: _____

Address: _____

1 (We) hereby authorize **Associates in Mental Health, SC (AiMH)**
900 Main Street, Suite 580 **Ph: 309-637-4266**
Peoria, Illinois 61602 **Fax: 309-637-9836**

☐ Karen M. Kyle, M.D. ☐ Matthew M. Preston, M.D. ☐ Baljit Singh, M.D. ☐ Andrew Wang, M.D. ☐ Hannah E. Morrissey, D.O. ☐ Ghassan Bitar, M.D.

☐ Christopher P. Holly, LCSW ☐ Edna Ng, LCSW, SAP, SAE ☐ Kendrick J. Bailey, LCPC ☐ Frandy S. Raso, LCSW ☐ Caleb H. Friedrich, LCSW

To ☐ Release ☐ Exchange ☐ Receive records or information as requested below:

Agency/Person to release/receive: _____

Address: _____

_____Ph: _____ Fax: _____

Specific Nature of Information to be disclosed – Please <u>initial</u> or place check mark by each requested item:

_____ Initial Psychiatric History/Evaluation
_____ Psychological Reports/Evaluations
_____ Lab/X-ray//Test Results
_____ Consultations
_____ Other_____

_____ Progress Notes
_____ Complete Medical Record
_____ Financial Information
_____ Contact/Discuss Treatment and Progress
_____ All Information

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

_____ Continuing (mental health/alcohol or drug abuse) treatment, care and continuity of care
_____ Therapist transition
_____ Other_____

_____ Billing and payment related matters
_____ Legal

This consent is **valid for one year from date signed** (unless otherwise specified). Other Date: _____

I understand that I may revoke this authorization by notifying AiMH at 900 Main St, Suite 580, Peoria, IL 61602 in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by AiMH in reliance on the consent.

I understand that AiMH **may not condition treatment** or quality of care upon completion of this form. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will **prevent disclosure of information.**

I understand that AiMH may, directly or indirectly, receive remuneration from another party in connection with the use or release of disclosed information. I understand that I also will be charged for review and copying of records.

I understand that the information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my mental health information. By signature, I knowingly and voluntarily authorize AiMH to use or disclose my health information in the manner described above.

_____/_____ _____/_____
Patient/Child Signature (12+ years) Date Witness Date

_____/_____ _____/_____
Parent/Legal Guardian Signature Date Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY:
Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosure.