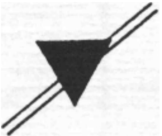
Associates in Psychiatry & Counseling

Please be advised that there is a charge for the copying and processing of your medical records. We need at least 10 business days to complete this process which are managed by MRO Document Manager. Your Records will be mailed to you. Status of your request can be obtained by calling - 610-994-7500. Please complete **ALL** portions of you request or we will not be able to honor your request.

Name: ____

Contact Number: ____

(847) 697-2400
FAX (847) 697-2438



Associates in Psychiatry and Counseling

2050 Larkin Avenue, Suite 202 Elgin,
Illinois 60123

Patient Authorization to Use or Disclose Protected Health Information

I hereby authorize, **Associates in Psychiatry & Counseling**, to release and exchange written, oral or electronically transmitted protected health information indicated below regarding:
Name: ______________________________ DOB: ___________
TO:
Name/Facility/Organization: ____
Address: ____
City/State/Zip Code: ____

For the PURPOSE of:

- o Disability
- o Information/ Medical Records Release
- o Verbal Exchange with Clinician(s)______________________for Coordination of Services

Information to be Released: *** **Dates of Services Requested**: From: __/__/____ to __/__/____.
( ) All Psychiatric Care (Evals, Progress notes, Medication record, Lab results)
( ) Substance Abuse Treatment
( ) Psychological Eval Results
( ) HIV Virus, HIV/AIDS, STD, and/or Venereal diseases
( ) Other: ____

- I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.
- I understand that when the 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 health information.
- I understand that Associates in Psychiatry & Counseling will not condition treatment or payment on this authorization.
- I understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
- I further understand that I retain the right to revoke this authorization. In order for the revocation of this authorization to be effective, Associates in Psychiatry & Counseling must receive the revocation in writing.

This authorization shall expire on _______________________________. After this date, Associates in Psychiatry & Counseling can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.
I fully understand and accept the terms of this authorization.

________________________________ _________ __________________________ __________
Patient's Signature Date Parent/ Guardian Signature Date
(**Patients 12 to 18 must sign in addition to the parent)**

________________________________ __________
Witness Signature Date