Psychological Services of Central Illinois (P.S.C.I.)
2921 Greenbriar Drive, Suite B-1
Springfield, IL 62704
P (217) 546-3118 F (217) 546-3184

Authorization for Release/Exchange of Mental Health Information

I, _____ hereby authorize the release/exchange of any and all records and information
(Person authorized to consent to release)

regarding _____ between _____ at PSCI and
(Name of Patient) *(Provider Name)*

Name of Person:
Name of Agency:
Address:
Phone:
Fax:

Nature of the information to be disclosed: _____

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

❑At the request of the individual ❑Continuity of Care ❑Therapist Transition ❑Billing/Payment
❑Housing and other arrangements/services ❑Consultation/advice/representation ❑Other *(specify)*:

Include the following information *(INITIAL all that apply):*

	Mental health information ***(PLEASE NOTE:** Psychotherapy Notes require a separate release)*		Drug/alcohol diagnosis, treatment, referral
	HIV/AIDs related treatment		Sexually transmitted disease
	Other *(list):*		

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 redisclose it without my written authorization. I understand that a copy of this release will be considered legal in lieu of the original document. I understand that my eligibility to obtain treatment cannot be contingent upon my consent to sign this authorization. I understand that if I refuse to consent to this release of information, the above-listed provider will not be able to obtain my records to assist in my treatment.

_____ _____
Signature of adult patient, parent, or guardian *Date*

_____ _____
Signature of child (if 12 years old or older) *Signature of 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 the parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

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REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the attached authorization for disclosure:

Signature of patient, parent, or guardian	Date
Signature of authorized agent (POA attached)	Signature of witness