Authorization to Release & Exchange Information

Patient Name: _____ D.O.B. _____ SSN: _____

Address: _____ Phone: _____

I, _____ hereby authorize _____ of CG Therapies, 6033 N. Sheridan Rd. #CW04S, Chicago, IL 60660, to release and obtain information (written/oral/electronic) to and exchange information to and from:

_____

Person/Facility Name Address City State Zip

_____

Person/Facility Phone Fax Number E-mail

Information to be released or disclosed:

[ ] Demographic information/Office Records
[ ] Psychiatric, Psychological, or other diagnostic Assessment/Testing/Evaluation
[ ] Medical History/Records/Labs/Medications
[ ] Treatment Planning/Summary Records
[ ] Discharge Planning/Summary Records
[ ] Attendance, participation, consultation, treatment in counseling sessions
[ ] Other:_____
_____

Concerning the care of the above patient from dates _____ to _____.
This abstract WILL include sensitive information such as mental, substance abuse, or HIV/AIDS unless checked below:
(Check all that apply)
___ Mental Health ___Substance Abuse ___HIV/AIDS ___ Other _____

These records are released/exchanged for the purpose of (check all that apply):
___ Continuity of Care ___ Attorney/Client Relationship ___ Insurance ___ At the request of the patient

My signature, giving consent, expires _____. The information released will be limited to the above identified requested information. The above requested information shall be released only to the requesting facility and the information may not be disclosed any further for any reason. I understand I have the right to inspect and copy the information released. It is further understood that I have been advised that I have the right to revoke this consent at any time. I understand that my refusal to consent to the release of information specified, will prevent disclosure of such information to the person named herein.

_____ _____ _____
Signature of Patient/Legal Representative Date of Signature Relationship to Patient

_____ _____
Signature of Witness Date of Signature

In sending this consent for Release of Information, I understand there is no charge for this information. If there is any charge for gathering this information and forwarding it to CG Therapies, please cancel this request.

The Standards for Privacy of Individual Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of information is expressly permitted by written consent of the person to whom it pertains by 42 CFR Part 2. A general authorization for release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997. Nov.2, 1987]