Advanced Psychiatry of Elgin

Child, Adolescent and Adult Psychiatry
2130 Point Boulevard, Suite 200
Elgin, IL 60123
Telephone: 847.783.0307 Fax: 847.783.0730

CONSENT FOR RELEASE OF PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

I hereby authorize Advanced Psychiatry of Elgin to: release_____ obtain_____ specified information in my medical/patient/educational record for the purpose of continued medical care.

_____

(Individual, Facility, or Organization)

_____

Address

_____ _____

Phone number **Fax number**

Information to be Used or Disclosed include the available items checked below:

____ Hospitalization _____ Consultation Report ____ Discharge Summary ____ Labs

____ Initial Evaluation _____ History & Physical ____ Treatment Notes ____ Other

____ Psychological Testing

I understand that my medical records and/or information in my connection with the hospitalization/treatment date(s) used for medical care may contain mental health, development disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency (AIDS)/HIV test results which are privileged and confidential and may be disclosed only on my authorization, except as required by law.

I UNDERSTAND THAT THIS CONSENT IS REVOKABLE AT ANY TIME PRIOR TO THE RELEASE OF THIS INFORMATION. THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE OF MY SIGNATURE, UNLESS I REVOKE IT.

I agree to release and hold harmless Advanced Psychiatry of Elgin, directors, officers, and employees from any and all liability, damages, claims, or suits, including reasonable attorney's fees, in connection with the disclosure of the records/information as authorized herein.

*****The Illinois medical record fee, Section 735 ILCS5/8-2014, allowed is ninety-nine cents (0.99$) per page for the first 25 pages, sixty-six cents (0.66$) for pages 26 through 50, and thirty-three cents (0.33$) for pages in excess of 50 pages.**

Patient Signature_____ Date_____