Authorization for Use or Release of Information

I hereby authorize: **Plum Tree 511 Illinois Avenue St Charles, IL 60174 P: 630.549.6245 F: 630.701.9500**
To obtain or release health information and records obtained during the course of care of:

Patient Name: _____ Date of Birth: _____

Address: _____ Patient's Phone: _____

_____

1. Information can be requested from and/or sent to the following person(s) or organization(s).

Person/Organization Name: _____

Address: _____

_____

Phone/Fax: _____

2. Purpose: The purpose of this request or disclosure is: _____

3. Information to be used or disclosed: The information includes only those items checked below. I understand that this authorization extends to all or part of the records/information designated below which may include treatment for a physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses. The information to be requested or released includes:

_____ History and Physical Exam _____ Psychiatric Evaluation _____ Psychological Testing
_____ Education Information _____ Medication Records _____ Drug/Alcohol Issues
_____ Treatment Plans _____ Progress Notes _____ Medical Diagnoses
_____ Verbal Communication With: _____
Other: _____
Specific Restriction: _____

4. (1) *Expiration*: Unless I revoke the authorization earlier, this authorization will expire in 180 days from the date it is signed. (2) *Re-disclosure*: Information disclosed in accordance with this authorization may no longer be protected by Federal Law, and could be use or re-disclosed by the receiving party. (3) *Refusal to sign*: I may refuse to sign this authorization. The consequences of refusing to sign are that my information will not be shared, which may make it difficult for the treatment provider to understand my history and provide comprehensive care. (4) *Revocation*: I have the right to stop the request or release of information at any time, but I cannot do anything about information that has already been obtained or released. (5) *Copy*: I can receive a copy of this completed form, upon request. (6) *Inspect and copy*: I have the right to inspect and copy the information to be disclosed.
(7) *Certification*: I certify that I am (check whichever applies):

_____ The patient, and the identification I have provided is true and correct.
_____ The patient's authorized representative, and that the identification I have provided is true and correct.

5. I hereby release Plum Tree, Ltd., including Dr. Weller and Plum Tree contracted mental health providers from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

Patient (Child)	Printed Name	Signature (if able)		Date
Guardian	Printed Name	Signature	Relationship to Patient	Date
Witness	Printed Name	Signature		Date