# Authorization for Stillpoint to Send Medical Record Information

**Name of Patient:** _____ **Date of Birth:**_____

**I authorize Stillpoint Mental Health Associates** to release the following:

☐ Entire Medical Record (or items indicated below)

☐ Personal Registration information
☐ Psychiatric history and evaluation
☐ Psychiatric medication list
☐ Office notes
☐ Alcohol/Drug Use information
☐ Lab Results
☐ Billing Information
☐ Other _____

**For dates of treatment of** ☐ All dates in record or ☐ _____
(List specific dates of treatment if desired)

**To:**

Name of agency or person receiving information: _____

Address of agency or person receiving information: _____

Telephone Number: _____ Fax Number: _____

**For the purpose of:** ☐ Coordinating Care ☐ Insurance Request ☐ Disability Determination
☐ Billing & Payment ☐ Other _____

This consent is valid for 365 days unless another date is specified: _____
(Enter a date if desired)

I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect and copy the information to be disclosed. It has been explained to me that this information may be transmitted via telephone, mail, and/or facsimile.

_____ _____
**Patient Signature** Stillpoint Staff Signature

_____ _____
**Date** Date

_____
(If signature is not of patient, indicate legal relationship to patient and legal basis for consent. )

Notice to Receiving Agency/Person: Under the provision of the Illinois Mental Health and Developmental Disabilities Act, and the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, you may not re-disclose any of these records or information from such records, unless the person who consented to this disclosure specifically consents and authorizes such re-disclosure.

Stillpoint Mental Health Associates, S.C.
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