Authorization for Release of Medical Record Information

Line 1 **Name of Patient:** _____ **Date of Birth:**___/___/____.

Line 2 I authorize: _____ (or) ☐ Stillpoint Mental Health Associates
(Name doctor/agency providing information)

Line 3 **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
- ☐ Hospital records on file in this office
- ☐ Other _____

Line 4 **For dates of treatment of** ☐ All dates in record or ☐ _____
(List specific dates of treatment if desired)

To:

Line 5 _____ (or) ☐ **Stillpoint Mental Health Associates .**
(Name of agency or person receiving information)

Line 6 _____ **(or)** ☐ **201 E. Ogden Ave, Suite 116 .**
(Address of agency or person receiving information) **Hinsdale, IL 60521 .**

Line 7 _____ **(or)** ☐ **Tel: 630-325-8893 Fax: 630-325-8939**
(Telephone and fax number of person receiving information)

Line 8 For the purpose of: ☐ Coordinating Care ☐ Insurance Request ☐ Disability Determination
☐ 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.

Line 9 _____ _____
Patient Signature Stillpoint Staff Signature

Line 10 _____ _____
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.
201 East Ogden Avenue, Suite 116, Hinsdale, Illinois 60521
Telephone 630.325.8893 ♦ Facsimile 630.325.8939

Directions for completing this form:

This form may be used to request records from a patient's other doctors, or to send information to someone else.

The patient or their representative must provide information required on every numbered line.

To use it to request records <u>from</u> another doctor, write that doctor's name after "I authorize" on Line 2, and check Stillpoint information on Lines 5, 6, and 7.

To use it to <u>send Stillpoint records</u> to another doctor or agency, check Stillpoint on Line 2, and write to whom and where records are to be sent on Lines 5, 6, and 7.

Patient or their representative should sign and date the form after completing it. Stillpoint staff person receiving the form should ensure that all required information is present, then sign and date the form.