GUADA
PSYCHOLOGICAL SERVICES

Authorization to Release Information Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist/clinician, _____ to release:

_____

This information should only be released to:

_____

I am requesting my psychologist to release this information for the following reasons:

_____

This authorization shall remain in effect until:

_____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

_____ _____

Patient Signature Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.