



**Centered: NorthShore Center for Mental Health**

**114 Kedzie Street, Suite 1 Evanston, IL 60202 847.334.3478**

**Release of Confidential Information**

Mail all Forms to:

**Centered: NorthShore Center of Mental Health**

**114 Kedzie Street, Suite 1**

**Evanston, IL 60202**

**(Phone) 847.334.3478**

Client Name: \_\_\_\_\_

DOB \_\_\_\_\_

**THIS IS A RELEASE FOR CONFIDENTIAL INFORMATION FROM YOU OR YOUR FACILITY TO KATELYN VARHELY, PSY.D, AUTHORIZING OUTSIDE AGENCIES OR INDIVIDUALS TO RELEASE CONFIDENTIAL PROTECTED HEALTH INFORMATION, PSYCHOLOGICAL INFORMATION, EDUCATIONAL RECORDS AND/OR ALCOHOL AND DRUG TREATMENT RECORDS TO RECEIVING AGENCIES/INDIVIDUALS:**

PLEASE NOTE THAT SINCE EACH ITEM WILL BE INDIVIDUALLY SPECIFIED, THIS FORM DOES NOT CONSTITUTE A GENERAL RELEASE OF INFORMATION.

ALSO NOTE THAT PATIENT SIGNATURE ALLOWS TREATMENT OF COPIES OF THIS FORM TO BE TREATED AS AN ORIGINAL. THAT IS TO MEAN YOU ARE TO HONOR THIS FORM AS HAVING THE SAME LEGAL OBLIGATION AND FORCE AS THE ORIGINAL SIGNED COPY.

**CLIENT AGREEMENT AND AUTHORIZATION TO RELEASE:**

This form when completed and signed by you, authorizes outside agencies or individuals to release protected information from your clinical record to Centered: NorthShore Center of Mental Health. by mail, facsimile, or personal communication. It authorizes any receiving individual or entity to honor copies of this signed form as having the same legal authority and force as the original. You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information.

**I authorize the following individuals, agencies or their representative to release to Centered: NorthShore Center of Mental Health. (Centered) and/or its administrative and clinical staff the following individually checked items in their entirety:**

- |   |   |
|---|---|
| <input type="checkbox"/> Intake Summary                               | <input type="checkbox"/> Hospital Admission and Discharge Summaries   |
| <input type="checkbox"/> Discharge/Treatment Summary                  | <input type="checkbox"/> Medical and Laboratory Results   |
| <input type="checkbox"/> Treatment Plan                               | <input type="checkbox"/> Alcohol and Drug Screen Results  |
| <input type="checkbox"/> History Forms                                | <input type="checkbox"/> Letters or updates to CPANCF   |
| <input type="checkbox"/> Mental or Psychiatric Examination            | <input type="checkbox"/> Alcohol and/or Drug Abuse Evaluation & Treatment   |
| <input type="checkbox"/> EMS Records                                  | <input type="checkbox"/> Confidential Psychological and Mental Health Information for Treatment Care Coordination |
| <input type="checkbox"/> Psychological and Neuropsychological Testing | <input type="checkbox"/> Current and Past Progress Notes  |
| <input type="checkbox"/> Raw Psychological Test Data                  | <input type="checkbox"/> Educational and Academic Records including results of                                    |

\_\_\_ Current and Future Progress Notes standardized testing and school psychological records.

\_\_\_ Participation, Progress and Attendance in Treatment

\_\_\_ Social History and Nursing Notes

\_\_\_ Emergency Room Records and Notes

\_\_\_ Patient History forms

Other:

\_\_\_\_\_  
\_\_\_\_\_

This authorization shall authorize for release of information from \_\_\_\_\_ to \_\_\_\_\_.

This authorization shall authorize for release of information from \_\_\_\_\_ until 120 days following the termination of therapy or closure of my case or file with Centered: NorthShore Center of Mental Health.

I am requesting the following providers or agencies to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

\_\_\_\_\_  
\_\_\_\_\_

This release shall authorize the following individuals or agencies to release the above specified information:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we or the receiving agencies or individuals 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.

By signing below you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Centered: NorthShore Center of Mental Health. 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 that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN/ID: \_\_\_\_\_

Signature of Patient or Authorized Representative \_\_\_\_\_ 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.