Authorization to Release Information

Client Name: ____ DOB: ________________

I authorize Goodman Psychologist Associates and its Affiliates to communicate with, release information to, and obtain records and information from:

Name: ____ Phone Number: __________________________________

Address: ____ Email Address: ___________________________________

Purpose of Release

Information to be Disclosed: ☐ Complete Record

- ☐ Facilitate evaluation and/or treatment
- ☐ Coordinate Treatment
- ☐ Billing
- ☐ Scheduling
- ☐ Other: ____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by send written notification to Goodman Psychologist Associates. I further understand that a revocation of the authorization is not effective to the extent that action taken in reliance of the authorization.

Expiration

This authorization will expire on the following date: _________________. If I do not specify an expiration date, this authorization will expire one year form the date of execution of this authorization.

Conditions

I further understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. Refusal to sign authorization will not affect my treatment. I also have the right to inspect and copy the information that is to be released.

Form of Disclosure

We reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, by facsimile, or electronically. Goodman Psychologist Associates does not use encryption technology for email and therefore, information being transmitted via email may be viewed by unauthorized person during transmission. I understand that it may be impossible to determine whether unauthorized access to email has taken place. In addition, email usage may be monitored by Goodman Psychologist Associates administration for internal security purposes.

Redisclosure

Federal and State law prohibits the person or organization to whom disclosure is made from making any further disclosures of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2 and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

_________________________	__________	__________________________________	______________
Signature of Client	Date	Signature of Parent, Guardian or Personal Representative	Date

(Clients ages 12-17 years old are requested to sign and date with co-signature of parent/legal guardian). If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).