

Joliet Center Clinical Research Mental Health Treatment Release of Information

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Allison Hubbard, LCPC Michael Wathen, LPC Richard Madison, LCSW Denise Jabaay, LCSW Dennis Waclawik, LPC Lauren Mahaffey, LCSW Intern

I, _____, whose Date of Birth is _____

Authorize Joliet Center Clinical Research, 210 N Hammes Ave, Suite 205, Joliet, IL 60435, 815-729-7790 to disclose to and/or obtain from:
The following information: Name of person, Organization, Address, and Phone Number (All information must be filled out or invalid)

Description of Information to be Disclosed

- | | | |
|--|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Presence / Participation in Treatment | <input type="checkbox"/> SOAP / Progress Notes |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Lab Results/ Imaging | <input type="checkbox"/> Verbal Exchange only, nothing written |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Current Treatment Update | | <input type="checkbox"/> All |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

Unless sooner revoked, this will expire one year from the Signature date: Or as otherwise

Indicated: _____

Expiration

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Joliet Center Clinical Research. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions

I further understand that Joliet Center Clinical Research will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Non-disclosure

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any matter that we deem to be appropriate and consistent with applicable law, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPPA privacy regulations, unless a State law applies that is more strict than HIPPA and provide additional privacy protections.

Signature of the Patient: _____ Date: _____

Signature of Personal Representative: _____ Date _____

Relationship to Patient if Personal Representative: _____

Witness: _____ Date: _____