

**CAROLINE M. MORRISON, M.D.**  
**1755 PARK STREET, SUITE 300**  
**NAPERVILLE, IL 60563**  
**PHONE: (630) 983-8920 FAX: (630) 983-4839**

**REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION**

Patient Name: _____		Date of Birth: _____	
Address: _____		City, State, Zip: _____	
Cell Phone: _____		Home Phone: _____	

I hereby authorize Caroline Morrison, M.D. to: (Check one or both)

Send copies of your psychiatric record to (or discuss information with) the provider/person/facility below:  
 Receive copies of your record from (or discuss information with) the provider/person/facility below:

Name of Provider/Person/Facility	Address	
City, State, Zip	Phone	Fax

**PURPOSE FOR THIS REQUEST:**  
 At the request of the patient/guardian  Coordination of services  Share/Receive Information Relevant to Treatment  
 Attorney/Court  Personal Use  Continuity of Care  Insurance Application  Other: \_\_\_\_\_

**TYPE OF RECORDS OR INFORMATION REQUESTED:**  
 Psychiatric Evaluation  Progress Notes  Discharge Summary  Summary of Diagnosis and Treatment  
 Medical History and/or Evaluation(s)  Labs/Test Results \_\_\_\_\_  
 Consultations/Evaluations  Verbal exchange of clinical information  Diagnosis  Prognosis  
 Other: \_\_\_\_\_

For the following dates of service: \_\_\_\_\_

I have a right to inspect a copy of any and all materials that I authorized to be disclosed. I understand that my records are protected under federal, state, and local regulations governing confidentiality and privacy of my treatment information, included but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent in writing at any time, except to the extent of actions that have already been taken in reliance on it. Further, I understand that disclosure of information to individuals or entities that are not covered by HIPPA regulations, such as parents, spouses, children, significant others, is not protected by HIPPA prohibitions on disclosures.

This consent expires:  
 120 Days from the date of this consent, or  On the following date, event, or condition: \_\_\_\_\_

_____ Patient Signature	_____ Printed Name	_____ Date
_____ Parent/Guardian Signature	_____ Relationship to Patient	_____ Date
_____ Witness Signature	_____ Printed Name	_____ Date