



# NAPERVILLE CLINICAL ASSOCIATES

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## 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 M. 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