PRA Perakis, Resis, Woods & Associates

PRA: Perakis, Resis, Woods & Associates
Authorization to Release Information

Return Fax Numbers by Office Location
Schaumburg Fax: 847-240-2418 Vernon Hills Fax: 847-918-8215 Crystal Lake Fax: 815-356-5094

Reason for Release: Check those that apply
○ Requesting records be sent to listed name ○ Request communication between PRA and listed name
○ To be added to Medical Record – no action needed ○ Other _____

Patients Name:	Birthdate: / /
Street Address :	Age:
City:	State Zip:
Phone: (cell) - -	Email:

I hereby authorize _____ **and**
(Your doctor/therapist at PRA)

Name: _____ Relationship: _____
(Person we are exchanging information with)
Address: _____
City_____ State_____ Zip Code_____
Phone: (_____) _____-_____ Fax: (_____)_____-_____

to ***(circle one or both)*** **release/receive** information contained in my patient records for dates
☐ all treatment dates ***or*** ☐ specific dates which include from _____ to _____, as identified and checked below:

Check box(s) of what part of your medical record you want to release:

- ☐ Medical History
- ☐ Chemical Dependency Evaluation/TX
- ☐ Psychiatric Evaluation
- ☐ Psychological Tests
- ☐ Redisclosure of _____
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consents/Intake/Authorizations
- ☐ Billing/Financial Information
- ☐ Other Specified: _____

The **purpose and need for disclosure**: ☐ for the purpose of assisting in the evaluation and treatment of this patient ***or***
_____.

The person or agency to whom information is disclosed may not redisclose this information unless I specifically consent to such redisclosures. This consent can be revoked in writing at any time unless the record holder has already taken action in reliance on my authorization. Without expressed written revocation, this consent expires after one year, or upon the following specific date, event or condition: ☐ treatment relationship is terminated ***or*** _____.

I understand that signing this authorization is voluntary. PRA may not limit or restrict services, treatment or care based on the signing of this authorization.

Patient Signature: _____ Date:_____/_____/_____
(Required for patients 12 and older)

Parent/Guardian Signature: _____ Date:_____/_____/_____

Witness: _____ Date:_____/_____/_____

For Office Use Only	**9/19**
Staff Person Releasing Information:	Date Information Released: