AUTHORIZATION TO RELEASE INFORMATION BETWEEN PRA CLINICIANS

RETURN FAX: 847-240-2418

Patients Name:	Birthdate:
Street Address	Age:
City, State, Zip:	Social Security #: - -
Maiden/Other Name:	Phone: (home) ( ) ____-_____ (work) ( ) ____-_____

I hereby authorize _____ **and**

PRA MD or Therapist

☐ PRA Schaumburg office ☐ PRA Crystal Lake Office ☐ PRAVernon Hills

_____

PRA MD or Therapist

☐ PRA Schaumburg office ☐ PRA Crystal Lake Office ☐ PRA Vernon Hills

to **discuss and receive** information about my treatment ☐ all treatment dates ***or*** ☐ specific dates, which include from _____ to _____, as identified and checked below:

☐ Psychiatric/Psychological Evaluation
☐ Access to Medical Record
☐ Ongoing treatment progress/notes
☐ Other _____

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

_____.

The person 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 180 calendar days, or upon the following specific date, event or condition: ☐ treatment relationship is terminated ***or***

_____.

Patient Signature: _____ Date: _____

(Required for patients 12 and older)

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

For Office Use Only	
Staff Person Releasing Information:	Date Information Released: