

AUTHORIZATION TO RELEASE INFORMATION
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**
(Your doctor/therapist at PRA)

Name: _____
(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:

- | | |
|--|--|
| <input type="checkbox"/> Medical History
<input type="checkbox"/> Chemical Dependency Evaluation/TX
<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Psychological Tests
<input type="checkbox"/> Progress Notes/Mental Health Treatment | <input type="checkbox"/> Outpatient Care
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Consultations
<input type="checkbox"/> Inpatient Care
<input type="checkbox"/> 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 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: