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
O Requesting records be sent to listed name O Request communication between PRA and listed name
O To be added to Medical Record – no action needed O 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:

1701 E. Woodfield Road, Ste. 1000
Schaumburg, IL 60173-5113
Ph (847) 240-2211 • Fax (847) 240-2418

350 E. Congress Parkway, Ste. C
Crystal Lake, IL 60014-6284
Ph (815) 356-5050 • Fax (815) 356-5094

3 W. Hawthorn Parkway, Ste. 150
Vernon Hills, IL 60061-1447
Ph (847) 918-8282 • Fax (847) 918-8215