AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, ____, hereby authorize ____Madraigos Midwest_____________________

(Client/Parent/Guardian) (Facility/Therapist/Counselor)

To: □ Release □ Obtain □ Release and Obtain any record or information regarding

____

(Client)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

□ ____ HIV/AIDS related treatment

□ ____Mental Health Information

□ ____ Psychotherapy notes

□ ____ Sexually transmitted diseases

□ ____ Drug/alcohol diagnosis, treatment/referral.

To_____________________________________ ____

(Receiving Agency/person) (Address)

For the purpose of: (Please check all that apply)

□ Continuing (health and mental health) treatment or care and continuity of care

□Therapist transition

□Housing and other arrangements and services

□Billing, payment and financial matters and arrangements

□Consultation, advice and representation regarding my condition and needs

□Other ____

This consent is valid until **(calendar date)** ____________________

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re-disclose it without my written authorization.

I also understand that if I refuse to consent to this release of information, the following may occur:

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(client under 18) (Signature of adult client or parent if client is under 18) (Date)

____

(Witness) (Date)

NOTICE TO PATIENT AND RECEVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

____________________________________ ____________________________________

(Client) (Date)

____________________________________ ____________________________________

(parent if client is under 18) (Date)