Konick & Associates

Authorization for Release of Information

I, _____ (PATIENT'S full name), hereby authorize Konick & Associates, P.C. to exchange/disclose information with the following individual OR agency:

Name/Agency/School: _____

Address and Telephone: _____

The type of information to be disclosed/exchanged (check all that apply):

Evaluations ( )	Medical/Hospital Records ( )
Diagnosis ( )	Psychological/Medical Test Results ( )
Treatment Plan ( )	Mental Health Record Summary ( )
Progress Notes ( )	Appointment Dates / Invoices & Billing ( )
Educational Records/IEP ( )	Other ( ) _____

Please initial the following items, if the information below will be used and/or disclosed:

_____ Mental Health/Developmental Disabilities information and/or records

_____ Drug/Alcohol diagnosis, treatment, and/or referral information

The purpose of such disclosure/exchange (check all that apply):

Continuity of care & treatment planning ( )	Consultation ( )	Scheduling ( )
Transfer ( )	Legal issues ( )	
Family Involvement ( )	Determination of Eligibility for Services ( )	
Payment and claims processing ( )	Other ( ) _____	

Restrictions if any: _____

The designated information may be transmitted by telephone, mail, fax, electronic mail, or other electronic file transfer mechanisms. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

This consent is in effect until_____ or, if not otherwise indicated, one year from the signature date below. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information regarding mental health and developmental disabilities, substance use/abuse, or AIDS under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Substance Abuse Confidentiality Requirements, and the Illinois AIDS Confidentiality Act. I understand that the named agency/facility/individual authorized to receive the information has the right to inspect and copy the information disclosed. I also understand that the person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. This to certify that I have given consent freely and voluntarily and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Signature of Minor (if age 12 or older) Date

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