APRIORIS
PSYCHOLOGICAL HEALTH SERVICES

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Authorization for Release of Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, _____, and/or his or her administrative and clinical staff (cross out if not applicable) _____ to release (be as specific and detailed as possible) : _____
_____
_____
_____

☐ Medical Information
☐ Insurance Information
☐ Diagnostic Information
☐ Progress Notes
☐ Progress Summary
☐ Session Attendance
☐ Initial Consultation
☐ Psychological Testing Report
☐ Neuropsychological Report

This information should only be released to:

Name: _____ Relation: _____
Address: _____
Phone Number: _____ Fax: _____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose)
_____

This authorization shall remain in effect until _____ (if no calendar date is stated, information may be released only on the day the authorization form is received by the psychologist.)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

Signature: _____ Date: _____
Printed Name: _____ DOB: _____

Signature of Legal Guardian: _____ Date: _____
Printed Name: _____ DOB: _____