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Psychiatry Studio
Wellness for children, teens & adults

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, (Your Name) _____, guardian of

(Patient's Name) _____, Date of Birth _____, authorize Psychiatry Studio to release mental health related information about to/and to receive from (Agency/Person Name and Direct Contact Information):

The information requested above is being released for the purpose of care coordination and is valid for the duration of treatment or earlier if revoked by the recipient.

The statues that govern this Authorization include, but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740ILCS110), 735 ILCS 5/8-2001 (Inspection and copying of hospital records), and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

I understand that I have the right to revoke this consent in writing at any time and that I have the right to copy and inspect the information being disclosed.

X _____ Date: _____
(Patient Age 12 or over)

X _____ Date: _____
(Parent/Guardian of minor or guardian of a legally disabled patient)

Notice to Receiving Agency/Facility/Person: Under federal law and applicable state laws, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.
Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without specific authorizations for such re-disclosure.