OAK BROOK BEHAVIORAL HEALTH

2803 Butterfield Rd., Suite 200, Oak Brook, Illinois 60523
(630) 424-0652 Adults / (630) 424-9204 Pediatrics

AUTHORIZATION TO RELEASE INFORMATION

Specified information will be released for the patient as indicated below, upon appropriate completion of this authorization.

Patient's Last Name ______________ First Name ______________ MI ____ Date of Birth ____/____/____

Phone Number ______________ Street Address ______________ City & State ______________ Zip Code ______________

Date(s) of service requested: ______________________________

Purpose of release: ____Continuation of Care ____Personal Reasons ____Insurance ____Legal

____Other (fill-in): ______________________________

Do you authorize communication between this office and your Primary Care Provider and/or Therapist?
_____Yes or _____No

Name of Primary ______________________ and/or Therapist ______________________

Patient Requests information released <u>to OBBH</u> from:	**OR**	**Patient Requests information <u>from OBBH</u> disclosed to:**
Name: ______________________		Name: ______________________
Address: ______________________		Address: ______________________
______________________		______________________
		FAX: ______________________

Requested information (Check those that apply):

_______ Progress Notes _______ Medication List

_______ Psychiatric Assessment _______ Psychological Testing _______ Neuropsychological Testing

Other (specify) ______________________________

NOTE: While Oak Brook Behavioral Health makes every effort to protect the privacy of your behavioral health information, please note that release of your medical information to the authorized person or organization could be the subject of redisclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act (HIPPAA) or other federal or state laws.

This authorization is valid for: one year from this date duration of treatment.
(circle one)

Signature of Patient ______________ Signature of Minor Patient (12-17 years old) ______________ Date ____/____/____

Signature of Parent/Guardian ______________ Relationship to Patient ______________ Date ____/____/____

*****Accounts must be in good standing prior to release of records.*****