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: _____ **Therapist:** _____

Ph: _____ **Ph:** _____

Patient Requests information released to OBBH from:

Name: _____

Address: _____

_____

OR

Patient Requests information from OBBH disclosed to:

Name: _____

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**

(check one of the above)

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

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

By typing your name, you agree that this serves as your electronic signature.