DASC CHICAGO

Depression & Anxiety Specialty Clinic of Chicago
3047 N. Lincoln Ave., Suite 400
Chicago, Illinois 60657
(773) 494-5505
www.dascchicago.com

Authorization For Release and Exchange of Information

Records to be released from/to:

Depression and Anxiety Specialty Clinic of Chicago
3047 N. Lincoln Ave., Suite 400
Chicago, IL 60657
Phone: 773-494-5505
Fax: 773-857-1164

Please mail authorization form to the address above.

Print Patient's Name _____

Address _____ City/State/Zip _____

Date of Birth ____ / ____ / _____ Social Security Number _____-____-_____ Phone ( ) _____

I _____hereby authorize Depression and Anxiety Specialty Clinic of Chicago (DASC) to release

(written/oral/electronic) information to:

Agency/Facility/Person _____

Address _____ City/State/Zip _____

Phone ( )_____ Fax ( ) _____

INFORMATION TO BE RELEASED

____ Discharge Summary ____ Clinic/Office Records ____ Psychological Testing/Assessment

____ Treatment Planning ____ Consultations ____ Integrated Assessment

____ Record Abstract (All progress notes, Integrated Assessment, Consultations, Psychological Testing, Treatment Plans and Reviews, and Other Diagnostic Tests

____ Patient review of record

____ Other (please specify) _____
_____
_____

Concerning the care of the above patient from dates _____ to _____

Consent to expire on (date) _____

This abstract WILL include sensitive information such as mental health, substance abuse, or HIV/AIDS unless checked below.
(Check all that apply; ONLY CHECK IF YOU **DO NOT** WANT THIS INFORMATION SHARED)

____ Mental Health ____ Substance Abuse ____ HIV/AIDS ____ Other _____

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These records are released for the purpose of (Check all that apply)

____ Continuity of Care ____ Attorney/Client relationship ____ Insurance ____ At the request of the patient

Allow (5-10) Business Days for Processing

I understand that I have the right to inspect and copy the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended.

_____

Signature: Patient or Legally Authorized Patient Representative Date of Signature

_____

Relationship to Patient

_____

Signature of Witness Date of Signature

The Standards for Privacy of Individual Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of information is expressly permitted by written consent of the person to whom it pertains by 42 CFR Part 2.

A general authorization for release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov 2, 1987]