THE OCD & ANXIETY CENTER
1100 Jorie Blvd. Suite 132 Oak Brook, IL 60523 630-522-3124

Authorization for Release of Information

Patient Name: _____
First Middle Last

Date of Birth: _____ Phone: _____
Month Day Year

Address: _____
Street Address

_____
Street Address Line 2

_____
City State Zip Code

1) I hereby authorize The OCD & Anxiety Center / _____ to release/disclose AND obtain/exchange written, oral, or electronically-transmitted protected health information to:

_____
Name of Provider/Organization/Individual

_____
Street Address

_____
Street Address Line 2

_____
City State Zip Code

_____ _____
Phone Fax

2) Regarding the above named patient.

3) Information may be disclosed/obtained by mail, e-mail, fax, phone, or in-person.
Specify restrictions, if any: _____

4) For the following purpose(s):
☐ Treatment Planning ☐ Psychological Assessment ☐ Psychiatric Evaluation
☐ Coordination/Continuity of Care ☐ Other: _____

5) Information to be disclosed:
☐ Name ☐ Address ☐ Phone Number ☐ Date of Birth (*All four must be selected for any information to be released*)
☐ Any and All Mental Health and Medical Information and Records including notes and ongoing communication (including all listed below)
☐ Do NOT release the following information: _____

6) For work letters: Work letters will be sent directly to Patient.

   ☐ Work letter may disclose treatment type and facility _____ (must initial)

   ☐ Work letter may NOT disclose treatment type and facility _____ (must initial)

7) This authorization is valid until calendar date: _____
   Month Day Year

8) By signing below, I agree that I have read and understand the following:
   - I may revoke this Authorization in writing at any time, except to the extent information was released or other action taken in reliance on it, or if obtained as a condition of insurance coverage and the insurer has legal rights to contest a claim or policy. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to: Privacy Official, The OCD & Anxiety Center, at 1100 Jorie Blvd. Suite 227, Oak Brook, IL 60523.
   - With certain exceptions, health care providers and others may not condition treatment, payment, or enrollment or eligibility for health plan benefits, on obtaining an authorization. Exceptions may exist if authorization was sought for research-related treatment, for health care solely to create information to be disclosed to third party (such as for a pre-enrollment physical), or health plan enrollment eligibility. If such activity was conditioned on this Authorization, I understand that refusing to sign it may result in the refusal of such treatment, payment, or other activity. I understand that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for the underlying services.
   - The potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections. Redisclosure is prohibited unless the person who consented to the disclosure specifically consents to redisclosure. However, once the above information is disclosed, there is the potential that it may be redisclosed by the recipients, and therefore may no longer be protected by the federal privacy law regulations.
   - The above identified protected health information may contain information related to mental health, developmental disabilities, alcohol and drug abuse, sexually transmitted diseases and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results and/or information UNLESS RESTRICTIONS ARE SPECIFIED ABOVE.
   - I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.
   - This Authorization shall expire, without my express revocation, one year following the date of signature unless otherwise indicated. I further understand that my health information may be electronically stored on a computer, as well as in hard copy and can be accessed by clinicians, mental health support personnel and other health care providers at other facilities including The OCD & Anxiety Center, who are authorized to participate in my care. I understand that I am authorizing the aforementioned information to be released orally, through copies of medical records and/or by e-mail or fax.

9) Furthermore, I hereby release and hold harmless The OCD & Anxiety Center, affiliated organizations, clinics and home health agency, and their respective staff, providers, directors, officers, employees, agents, successors assigns and attorneys, from and against any and all liability, damages, claims, or suits, including reasonable attorney of the information as identified above.

* * * * *

_____ _____
Patient Signature (if over age 12) Date

_____ _____
Parent/Guardian Signature (Clients ages 12-17) Date

If signed by a Legal Representative, please indicate the relationship to the patient or authority to act for the patient:

_____