GENESIS CLINICAL SERVICES

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL MENTAL HEALTH INFORMATION

PLEASE CHECK APPROPRIATE USE:

☐ Speak with ☐ Release records to: ☐ Obtain records from: ☐ Keep on file

NAME _____

ADDRESS _____
STREET CITY STATE ZIP

PHONE NUMBER _____ **DATE OF BIRTH** _____

NAME OF GENESIS PROVIDER: _____
Phone: 630 653-6441 Ex: _____

I hereby authorize Genesis Clinical Services to release/exchange my personal health information to include mental/behavioral health information:

TO PERSON/AGENCY: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ **FAX:** _____

DISCLOSURE TO INCLUDE THE FOLLOWING INFORMATION: (Check which apply)

☐ Verbal Discussion of Case
☐ Lab reports
☐ Treatment Summary/Notes
☐ Account information
☐ Hospital Admission/Discharge Summary
☐ Dates of Treatment _____
☐ Psychological Testing
☐ Other: _____
Please Specify

THIS INFORMATION IS TO BE USED FOR THE FOLLOWING PURPOSES:

☐ Payment of account
☐ Diagnosis & Ongoing Coordination of treatment
☐ Other _____
Please specify

I have a right to inspect and copy the health information to be released, and if I do not sign this authorization, the organization named above will not release my personal health information. In addition, I understand that the organization named above will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that I may be responsible for the cost of medical record copying service.

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked. This release is valid for one (1) year from the date signed.

_____ _____
SIGNATURE OF PATIENT(anyone 12 and older must sign for themselves) DATE

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
WITNESS DATE

****Patient and Witness signatures are both required to validate this form. Parent may sign on witness line for children 12 and older unless the release is for the parent*****

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