COMPREHENSIVE CLINICAL SERVICES, P.C.

Main Office: 2340 S. Highland Ave, Ste 300, Lombard IL 60148
Phone # 630.261.1210 - Fax # 630.261.1211 - Discoverccs.org

RELEASE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give permission for an individual to contact CCS regarding your health care information.
Failure to provide all information requested may invalidate this authorization.

Name of Patient ____________________________________ Date of Birth ________________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Comprehensive Clinical Services, P.C.

To release to ____

Phone # _______________________________ Fax # __________________________________ ___

A. I specifically authorize the release of the following information (Check as appropriate):
   - ❑ Scheduling appointments
   - ❑ Patient Portal Access
   - ❑ Discuss patient care/recommendations
   - ❑ Billing/ Payments

Patient Initials required:

____ I understand that the information in my medical record may include information about behavioral or mental health services and treatment for alcohol or drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless otherwise specified above.

____ This authorization remains valid for two years from date of signature.

____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

The purpose of the release of information is:

- ❑ Continuity of medical care
- ❑ Pending legal action
- ❑ At the request of the patient
- ❑ Other (Specify): ____

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MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility of benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Comprehensive Clinical Services, P.C., 2340 S Highland Ave, Ste. 300, Lombard, IL 60148

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient and no longer protected by HIPAA.

SIGNATURES

____

Patient/Legal Representative Signature   Date

____

Print Patient/Legal Representative Name

____

Legal Representative's Relationship to Patient

____

Witness Signature   Date

____

Print Witness Name