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

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all the information requested may invalidate this authorization.

I hereby authorize Comprehensive Clinical Services, P.C. to use, release, disclose, receive and/ or exchange mental health and medical information concerning:

Name of Patient: _____ Date of Birth: _____

This information will be disclosed to and/or exchanged with:

Name/School/Agency: _____

Relationship to Patient:

- ❑ Parent or Legal Guardian
- ❑ Psychiatrist
- ❑ Therapist/Social Worker
- ❑ Primary Care Physician
- ❑ School Personnel
- ❑ Other: _____

Phone #: _____ Fax #: _____

Address: _____

Email: _____

A. The following information is to be released (Check as appropriate):
   - ❑ Entire record – Date of Service: _____
   - ❑ Assessment/history and physical – Date of Service: _____
   - ❑ Discharge summary – Date of Service: _____
   - ❑ Lab test – Date of Service: _____
   - ❑ Other (Please specify needed information and date(s) of service if known): _____

B. I specifically authorize the release of the following information (Check as appropriate):
   - ❑ Mental health treatment information
   - ❑ Mental health Psychotherapy notes
   - ❑ Alcohol/drug treatment information
   - ❑ Genetic information/testing

The undersigned affirms that I agree with:

- ❑ 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 the 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:

- ❑ Insurance or other third-party reimbursement
- ❑ Continuity of medical care
- ❑ Pending legal action
- ❑ At the request of the Patient
- ❑ Other (Specify): _____

I authorize the information to be disclosed through:

- ❑ Both Verbal and Written Communication
- ❑ Verbal Communication
- ❑ Written Communication

RESTRICTIONS

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Comprehensive Clinical Services, P.C., its independent contractors, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

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

_____	_____	_____
Date	Patient Signature (*Required if 12 years or older)*	Printed Name
_____	_____	_____
Date	Parent/Legal Guardian/Other Authorized Agent Signature (*if applicable*)	Printed Name
_____	_____	_____
Date	Witness Signature	Printed Name