AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , authorize Near North Health, to:
Please print your name.

Please initial all items that apply: ☐ release to ☐ obtain from ☐ discuss with

_____
Receiving or sending agency and/or person *Please print.*

_____
Address City State ZIP code

the following information: (*Please initial each item.)*

- ☐ Intake Evaluation
- ☐ Demographic Information
- ☐ Medical History
- ☐ Psychological Testing Report
- ☐ Medications
- ☐ Diagnosis HIV/AIDS
- ☐ Dates of treatment
- ☐ Screenings/Outcome Measures
- ☐ Treatment Plan
- ☐ Process Notes
- ☐ Psychiatric and/or Psychological Evaluation
- ☐ Treatment Summary
- ☐ Social History
- ☐ Alcohol/Substance Use
- ☐ Developmental Disabilities
- ☐ Other: _____

Dates of _____ to _____ for the purpose of:

Please initial each item:

☐ Evidence of Care ☐ Continued Treatment ☐ Treatment Coordination ☐ Other: _____

I understand that I may revoke this consent at any and that I have the right to inspect and copy the information to be disclosed. I understand that my refusal to consent in writing to release the above-mentioned information will prevent the disclosure of my information with no penalty to my care. If not revoked, this authorization will expire _____ days from the date signed.

_____ _____
Participant Signature Today's Date Parent/Legal Guardian Signature Today's Date

_____ _____
Witness/Clinician-in-Training Today's Date Near North Health Licensed Clinician Today's Date

To the receiving agency/person: Under provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. In addition, under Title 42 of the United States Code, Confidentiality of Substance Use Disorder Patient Records (amended 7/1/22), no such records, nor information from such records, may be further disclosed without specific authorization of such a redisclosure.