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## Release of PHI Authorization Form

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the entity you designate.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Agency or Practitioner: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*I authorize the above named agency or practitioner to:*

Provide to (initial: \_\_\_\_\_)  Receive from (initial: \_\_\_\_\_)

*Dr. Jessica A. Golub the following checked information only regarding the above named patient*

- confirmation of application for services
- report of intake, assessment, diagnosis, and/or service recommendations
- report of treatment and/or interventions
- closing or discharge summary
- Other (specify): \_\_\_\_\_

for the purpose(s) of: \_\_\_\_\_

This consent is valid until: \_\_\_\_\_

The patient has the right to revoke this authorization, in writing, at any time by sending such written notification to the office address shown on this letterhead. However, your revocation will not be effective to the extent that your therapist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.