COMPREHENSIVE CLINICAL SERVICES, P.C.

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

I hereby authorize: **Comprehensive Clinical Services, 2340 S. Highland Ave., Suite 300, Lombard IL 60148**
Phone: 630-261-1210 ● Fax: 630-261-1211 ● discoverccs.org

to use or release health information and records obtained during the course of treatment of :

Patient Name:_____ Date of Birth:_____
By: _____*(provider name)* For Dates of Service _____*to* _____

The information is to be used or disclosed to/from the following person or organization:

Person/Entity
Name:_____Title:_____

Location:_____Phone/Fax:_____

The information to be used or disclosed includes only those items checked below. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical/mental illness, alcohol/drug abuse.

___ Physical Exam, Lab/Test Results, Medical Progress notes from the past year
___ Mental Health Assessment, Psychotherapy Progress notes
___ Psychological Testing Results
___ School Reports, including: IEP, 504 plans, School psychologist records
___ Other: _____

The purpose of the use or disclosure is:

___ Continuing (mental health/alcohol and/or drug abuse) treatment or care and continuity of care
___ Therapist transition
___ Other _____

This consent is valid until _____, unless revoked beforehand.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I also understand that I may refuse to sign this authorization and that Comprehensive Clinical Services will not condition treatment on whether I sign this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

_____ _____
(Patient Signature – Adult or Parent/Guardian)) *(Date)*

_____ _____
(Patient Signature – Minor 12-17 years inclusive) *(Date)*

_____ _____
(Witness) *(Date)*