AUTHORIZATION TO RELEASE INFORMATION

RETURN FAX: 847-240-2418

Patient=s Name:	Birthdate:
Street Address	Age:
City, State, Zip:	Social Security #: - -
Maiden/Other Name:	Phone: (home) ( ) ____-_____ (work) ( ) ____-_____

I hereby authorize _____ **and**

(Your doctor/therapist at PRA)

Name: _____

(Person we are exchanging information with)

Address: _____

City_____ State_____ Zip Code_____

Phone: (_____)_____ Fax: (_____)_____

to ***(circle one or both)*** **release/receive** information contained in my patient records for dates □ all treatment dates ***or*** □ specific dates which include from _____ to _____, as identified and checked below:

□	Medical History	□	Outpatient Care
□	Chemical Dependency Evaluation/TX	□	Discharge Summary
□	Psychiatric Evaluation	□	Consultations
□	Psychological Tests	□	Inpatient Care
□	Progress Notes/Mental Health Treatment	□	Other Specified: _____

The purpose and need for disclosure: □ for the purpose of assisting in the evaluation and treatment of this patient ***or*** _____.

The person or agency to whom information is disclosed may not redisclose this information unless I specifically consent to such redisclosures. This consent can be revoked in writing at any time unless the record holder has already taken action in reliance on my authorization. Without expressed written revocation, this consent expires after 180 calendar days, or upon the following specific date, event or condition: □ treatment relationship is terminated ***or***

_____.

Patient Signature:_____ Date: _____

(Required for patients 12 and older)

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

For Office Use Only	
Staff Person Releasing Information:	Date Information Released: