IntraSpectrum Counseling
180 N Michigan Ave | Suite 1830 | Chicago | Illinois | 60601 T: (312) 379-9476 | F: (312) 263-1933
records@intraspectrum-chicago.com

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize IntraSpectrum Counseling to: ☐ release ☐ obtain ☐ release & obtain
information concerning the care of the below named person:

1. Client Legal Name:______________________________
2. Client Preferred Name/Also Known As:______________________________
3. Date of Birth:______________________________ Client ID #:______________________________

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4. I authorize information concerning:
☐ all episodes of care ☐ service dates ________________ through ____________________

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5. For: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial/Benefits
☐ Attorney ☐ State Law/Court ☐ Death ☐ Other:____________________
☐ Evaluation, Treatment Coordination, Monitoring, and Treatment Referral

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6. I authorize: ☐ **ALL** information in my entire record ☐ only **SPECIFIC** information
If specific information, I authorize information contained in:

☐ Appointments/Attendance
☐ Consultations
☐ Intake Assessments
☐ Medications/Prescriptions
☐ Psychiatric Evaluations
☐ Social History
☐ Assessments
☐ Diagnostic Summaries
☐ Labs/Test Results
☐ Patient Review/Summaries
☐ Record Abstract
☐ Substance Use Assessments
☐ Case Termination Summaries
☐ Financial
☐ Medical Administration Records
☐ Photos
☐ Service/Treatment Plans
☐ Other:______________________________ ☐ Other:______________________________

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7. It is my full understanding that the records and communications to be disclosed **WILL** include sensitive information, such as evaluation, habilitation, and treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, and HIV/AIDS. **CHECK ONLY FOR EXCLUSIONS**
☐ Alcohol/Substance Abuse ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Mental Health
☐ Other:______________________________

I authorize information to be released to/obtained from:

8. Entity Name (if applicable):______________________________
9. Individual(s):______________________________
10. Relationship(s):______________________________
11. Address:______________________________
City / State / Zip Code:______________________________
Phone:______________________________ Fax:______________________________
Email:______________________________

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12. I authorize information to be released/obtained via mail, in-person, phone, email, and/or fax.
CHECK ONLY FOR EXCLUSIONS ☐ Mail ☐ In-Person ☐ Phone ☐ Email ☐ Fax

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13. This authorization is valid for: ☐ One Year ☐ 90 Days ☐ Specific Date:____________________

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14. I understand that mental health, developmental disabilities, alcohol or substance use/abuse, and HIV/AIDS treatment records are protected under state and federal laws and regulations governing the confidentiality of such records and cannot be disclosed without written consent unless otherwise provided for by the laws and regulations. Persons receiving confidential information may not further disclose such information if the information concerns mental health, developmental disabilities, alcohol or substance use/abuse, and HIV/AIDS treatment records.

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15. The Standards for Privacy of Personally Identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a redisclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987).

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16. I understand that the above-named entity or individual(s) authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider or plan covered by the HIPAA Regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations. I understand that if I authorize disclosure using a general designation, that I will be provided a list of entities to which the information has been disclosed.

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17. I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to records department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received. I understand that no revocation of this authorization will be valid to the extent that action has been taken in reliance of this authorization.

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18. I understand that refusal to sign this Authorization to Release/Obtain Information will not jeopardize the right for the named client to obtain present or future psychiatric/psychotherapy treatment. I understand that the care, as well as payment for said care, for the named client at IntraSpectrum Counseling will not be affected if I do not execute this Authorization to Release/Obtain Information. I understand that refusal to execute this form will result in information not being released/obtained.

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19. . I understand that the specific information about disclosures and dates shall be documented in the named client's clinical record and that a facsimile of this authorization shall have the same force and effect as the original.

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20. I understand that I may request an electronic copy of client records at no cost once every six months and that I will be charged a fee of $20.00 plus $0.18 per page for any additional request, as well as all requests for paper records.

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21. Signature of Client (Age 12+):______________________________
22. If signing below on behalf of client, please check basis for your authority. Documentation may be required.
☐ Parent of Minor ☐ Guardian ☐ Power of Attorney ☐ Other Authorization:______________________
23. Signature of Authority:______________________________
24. Printed Name of Authority (or Witness if signed below):______________________________
25. Signature of Witness (if client signs by mark):______________________________

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26. Employee Receiving Authorization (Printed):______________________________
27. Employee Processing Authorization (Printed):______________________________
28. Signature of Employee Processing Authorization:______________________________
29. Date Authorization Received: ______________________ Processed:______________________