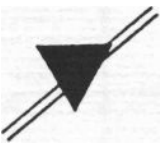
Associates in Psychiatry & Counseling

Please be advised that there is a charge for the copying and processing of your medical records. If choosing to sign a release through our office it will take up to 10 business days. Processed requests will be mailed. You can also access your records in less time yourself through our website at AIPC-ELGIN.com and/or have them sent to a third party. ABT manages all our Medical Release requests. Status of your request can be obtained by calling 1(855) 307-4340. Please complete **ALL** portions of you request or we will not be able to honor your request.

(847) 697-2400
FAX (847) 697-2438



Associates in Psychiatry and Counseling

2050 Larkin Avenue, Suite 202 Elgin,
Illinois 60123

Patient Authorization to Use or Disclose Protected Health Information

I hereby authorize, **Associates in Psychiatry & Counseling**, to release and exchange written, oral or electronically transmitted protected health information indicated below regarding:
Name: _____ DOB: _____
TO:
Name/Facility/Organization: _____
Address: _____
City/State/Zip Code: _____

For the PURPOSE of:

- ◯ Disability
- ◯ Information/ Medical Records Release
- ◯ Verbal Exchange with Clinician(s)_____for Coordination of Services

Information to be Released: *** **Dates of Services Requested**: From: __/ __/____ to __/ __/____.

- ☐ Psychiatric Care (Evals, Progress notes, Medication record, Lab results)
- ☐ Substance Abuse Treatment
- ☐ Psychological Eval Results
- ☐ HIV Virus, HIV/AIDS, STD, and/or Venereal diseases
- ☐ Other: _____

- I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.
- I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.
- I understand that Associates in Psychiatry & Counseling will not condition treatment or payment on this authorization.
- I understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
- I further understand that I retain the right to revoke this authorization. In order for the revocation of this authorization to be effective, Associates in Psychiatry & Counseling must receive the revocation in writing.

This authorization shall expire on _____. After this date, Associates in Psychiatry & Counseling can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.
I fully understand and accept the terms of this authorization.

_____ _____ _____ _____
Patient's Signature Date Parent/ Guardian Signature Date
(Patients 12 to 18 must sign in addition to the parent)

_____ _____
Witness Signature Date