GRAND OAKS
BEHAVIORAL HEALTH

Libertyville Office:
1800 Hollister Drive, Suite 201
Libertyville, IL 60048-5263

Northbrook Office:
3000 Dundee Road, Suite 111
Northbrook, IL 60062

Authorization Form

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

I _____ *(Patient Name)* authorize my Psychologist / LCSW / LPC and/or her/his administrative staff to:

☐ release necessary information from my clinical record

☐ obtain necessary information from my clinical record

This information should only be

☐ released to: _____

☐ obtained from: _____

I am requesting my psychologist/LCSW/LCPC to ☐ release ☐ obtain this information for the purpose of:

_____

_____

This authorization shall remain in effect for one (1) year from the date of signature.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 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	Legal Guardian	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.