DR.. HOWARD K. WEISSMAN, PSY. D.

ADULT

1440 Techny Road Northbrook, Illinois 60062
Phone: (847)-412-0922 **Fax:** (847)-412-0756

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND PERSONALLY IDENTIFIABLE INFORMATION

I, the undersigned, do hereby authorize the release and exchange of any and all oral and written information concerning myself, _____from any public or private agency, including but not limited to those listed on reverse, to Dr. Howard Weissman, 1440 Techny Road, Northbrook, Illinois 60062. The information requested below is being released for the purpose of assisting Dr. Weissman in my treatment. I understand that I have the right to limit this consent and choose not to do so at this time.

This release authorizes disclosure of any and all oral or written social history, medical, academic, psychological, psychiatric, or educational planning and testing information. In the case of a mental health facility, the complete disclosure of medical chart and running record or patient log information is authorized. Medical chart information shall include intake and discharge summaries, nursing entries, medical reports, consultations, operating room logs, medication logs, or any other information relating to the above named individual. I further understand my right to inspect, copy, challenge, and/or amend the subject records.

I understand that should I refuse to sign this release; the requested information **will not** be disclosed. I understand that I have a right to inspect and copy all information, and that I have the right to revoke this authorization in writing. Being fully apprised of these rights, it is my intent that this release remain force and effect until revoked in writing by the undersigned parties, or until the **expiration date** below, whichever comes first, in order that Dr. Weissman can be fully informed on a continual basis without the necessity for repeated requests.

I further intend that carbon, FAX, photocopies, e-mail or any other form of electronic transmittal of this release shall have the same force and effect as the original, and shall apply to all records requested.

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing the Authorization that the party releasing records cannot guarantee that the recipient receiving the requested information will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug/alcohol abuse, HIV, and mental health treatment.

PERSONS, AGENCIES OR ORGANIZATIONS TO WHICH THIS RELEASE IS DIRECTED:

Name:_____

Address:_____

Phone: _____ **Fax:**_____

Email Address:_____

SIGNED: XX _____ AGE: _____ DOB:_____
SERVICE RECIPIENT IF 12 OR OLDER (MENTAL HEALTH ONLY)

DATE: _____ WITNESS:_____

EXPIRATION DATE: _____