CENTRAL ILLINOIS PSYCHIATRIC ASSOCIATES

Raju N. Paturi, MD • Dawn M. Leedie, LCPC

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____
Client Name *DOB*

Authorize: ☐ **Release to:** ☐ **Exchange to:**

_____	_____
Name	***Name***
_____	_____
Address	***Address***
_____ _____	_____ _____
Phone ***Fax***	***Phone*** ***Fax***

the following information from my records:

- ☐ Assessment
- ☐ Diagnosis and Treatment Plan
- ☐ Psychiatric/Medical History
- ☐ Session Attendance Dates/Times
- ☐ Progress to Date
- ☐ Other

for the purpose of disclosure being:

- ☐ Coordination of Care
- ☐ Transfer of Care
- ☐ Patient Request
- ☐ Benefit Eligibility/Payment for Services
- ☐ Other

This authorization is valid until _____ (specific date)

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken, and that I have the right to review and request copies of the information to be disclosed. I understand and agree that a reproduction of the authorization will be valid with the same authority as the original. I further waive and release Central Illinois Psychiatric Associates (CIPA) from liability resulting in the release/obtaining of the above information. I understand that CIPA may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I further understand that the potential exists for the re-disclosure of my private mental health information, and that it may no longer be protected under HIPAA privacy regulations. If this form is used for the purpose of transfer of care to another psychiatrist, it is considered a termination of treatment with CIPA.

_____	_____
Client Signature	***Date***
_____	_____
Parent/Guardian Signature	***Date***
_____	_____
Witness	***Date***

NOTICE TO RECEIVING AGENCY/PERSON: Under the provision of Illinois Mental Health and Developmental Disabilities Confidentiality Act (Ill Rev. Stat., ch 91 ½ par 801 et seq) you may not disclose any of this information unless the person who consented to this disclosure consents to re-disclosure.

CENTRAL ILLINOIS PSYCHIATRIC ASSOCIATES, INC.
405 KAYS DRIVE STE B, NORMAL, IL 61761
PHONE: 309-862-0064 FAX: 309-862-1542