**AUTHORIZATION FOR RELEASE OF INFORMATION**
FOR CONSULTATIVE CARE ONLY

NAME (print) _____ _____
(last) (first)
ID# _____ DOB _____

**I AUTHORIZE:** _____

_____

_____

**TO RELEASE THE FOLLOWING SPECIFIC INFORMATION:**
_____
_____
_____
_____

**THIS INFORMATION IS BEING REQUESTED FOR THE FOLLOWING PURPOSE(S):**
_____ Continuity of care
_____ Other (please specify) _____
_____
I understand that:

- I may inspect and copy the information that I authorized to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at any time.
- My refusal to consent to the use of disclosure of the above mentioned information will prevent the disclosure of the information.
- If not revoked, this authorization will expire 1 year from this date or on _____(date).
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected under HIPAA. However, this information will continue to be protected by Illinois law.
- I understand by signing this release, **if applicable, HIV/AIDS or genetic information, drugs/alcohol, and/or mental health records will be included.**

Note: Standard charge for copies is $1.00 per page.

**RELEASE TO:** _____

_____

_____

SIGNATURE _____ DATE _____

WITNESS TO SIGNATURE_____

PATIENT'S TELEPHONE NUMBER _____