ALONG THE PATH COUNSELING SERVICES, P.C.

433 S. Phelps Avenue, Suite 2 • Rockford, IL 61108 • Phone: (815) 397-4287 • Fax: (815) 397-3136

Authorization for Use or Disclosure of Medical Records or Other Health Information

Law requires written authorization from the patient. All items must be complete to be considered valid.

1. Patient Name _____

   Address: _____

   City/State/Zip: _____

   Date of Birth _____ Telephone #: _____

2. I authorize the use and/or disclosure of Medical Record or Other "Health Information" as described below.

   a) Name, Address, and Phone Number of Organization or Person authorized **to RELEASE** the Health Information:

   _____

   _____

   _____

   b) Name, Address, and Phone Number of Organization or Person authorized **to RECEIVE** the Health Information:

   _____

   _____

   _____

   c) Please **SPECIFY** information to be released:

   _____

   _____

   _____

   d) Relationship to patient: _____

   e) Purpose of Authorization: ☐ Transfer of Care ☐ Coordination of Care ☐ Other: _____

3. I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, HIV test results, developmental disabilities, and genetic testing results unless I give written instructions not to release such information.
4. I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do it in writing and present it to Along The Path Counseling Services P.C. at the address listed above. I understand that the revocation will not apply to information that has already been released.
5. I understand that I have a right to inspect and/or receive a copy of the Health information to be released and that I may be charged a fee for any copies of the medical records that I receive.
6. I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form.
7. This authorization shall extend to records of future treatment, as long as such treatment occurs while this authorization is in effect. If no prior notice to revoke this authorization is received, this authorization will expire on (select one):

   ☐ One Year from Date Provided Below ☐ From the time Period: _____ to _____

8. I further understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy rules.
9. I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness