MENTAL HEALTH SOLUTIONS

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Mundelein, IL 60060

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Suite 2B
Crystal Lake, IL 60014

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101 Lions Drive, Ste. 115
Barrington, IL 60010

Phone: (847) 566-0164 Fax: (847) 566-0375

Mental Health Solutions ("MHS") AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes MHS to release protected information from your clinical record to the person(s)/facility that you designate and/or to communicate with designated person(s)/facility, including the collection of such protected information.

_____ _____
Print Patient's Name Date of Birth

_____
Patient's Address

I authorize my provider,_____ and/or his/her administrative and/or clinical staff to release:

____School Staffing Summaries
____Court/Probation Office Records
____Psychiatric Discharge Summary
____Evaluation/Progress in Therapy
____Medical History Records
____Psychological/Neuropsychological Testing
____Vocational Testing
____Social/Developmental History
____Date of First & Last Contact
____Other_____
(including psychotropic meds)

This information should only be released to: (print name and address)

_____

This authorization shall remain in effect for 180 days from the date of my signing this document. Nevertheless, I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the PO Box above. However, my revocation will not be effective to the extent that MHS or any authorized mental health professionals/staff have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insured has a legal right to contest a claim.

I understand that my provider generally may not condition professional services upon my signing an authorization unless said provider's services are provided to me for the purpose of creating health information for a third party.

I understand that my refusal to authorize the release of information specified above will prevent disclosure of such information and may have the following additional consequences, if any (provider us only:)

_____

_____

I understand that I have the right to inspect the disclosed mental health information at any time.

_____ _____
(Patient's Signature) (Date)

_____ _____
(Parent/Guardian's Signature) (Date)

_____ _____
(Witness) (Date)

If 18 years of age or older, only patient's signature is necessary. Both patient and parent/guardian must sign if patient is 12 – 17 years of age. If patient is under 12 years of age, parent/guardian only needs to sign.