AUTHORIZATION FOR RELEASE and/or EXCHANGE OF INFORMATION

Date: _____

I, _____ _____ _____
Last Name **First** **MI**

Given/ Maiden Name: _____ **Date of Birth:**_____

Address: _____ **Phone:** (_____) _____
Street

_____
City **State** **Zip**

hereby authorize and request: **Name** _____
Business/Organization River Rock Psychotherapy & Consulting, Inc. & Staff_____
Address 4753 N. Broadway, Suite 608_____
City Chicago_____ **State** IL____ **Zip** 60640_____
Phone (773) 659-9207_____

to (***Circle Intention***) release and/or exchange information to:
Name _____
Business/Organization Blue Cross Blue Shield _____
Address _____
City _____ **State** _____ **Zip** _____
Phone _____ **Fax** _____

This information will be used for the purpose of: billing treatment_____
_____

and is confined to the following ***specified*** and ***initialed*** information: diagnosis and appointment times only.___
_____
_____
_____

THIS AUTHORIZATION IS VALID UNTIL: _____
(must have date within next 12 months)

I understand that I may revoke this authorization at any time, but not retroactive to the release of information made in good faith, by writing to the above specified parties.

I understand that information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

It has been explained to me that if I decline to consent to this release of information, the following are the consequences: Specify (if any): responsibility to pay for services out of pocket._____

_____ _____
Signature of Person Authorizing **with date** **Signature of Witness** **with date**

Therapist_____
State relationship to client

NOTE: Authorization must be filled out in its entirety in order to be valid.

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, Ill. Rev. Stat. Ch. 91 ½ PAR. 805 (d) (1979), you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such disclosure.