HINSDALE PSYCHIATRY, S.C.

Sapana Chokshi, MD Adult Psychiatrist
Jabeen Ali, MD Child & Adolescent Psychiatrist
Stephanie Bakosh, MSN, APN, ANP-BC
Carmen T. Adams, MSW, LCSW
Elizabeth Meyers, LCPC
Tammy Fox, LCPC

Authorization to Release Outpatient Records & Information

I,____, hereby request & authorize

____

to release the information which is contained in any outpatient psychiatric, psychotherapy, alcohol &/or substance abuse records, including any & all information gained in interviewing & examining including, but not limited to, any outpatient treatment.

The persons or entities, including oneself, authorized to receive the information and records covered by this consent are: *(Please provide relationship/position, name, address, fax & telephone number)*

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The information & records which may be released are limited to all medical records or other information obtained by ***Hinsdale Psychiatry, S.C.*** through interviews or inquiries concerning or obtained from other persons, and will include all outpatient psychiatric, psychotherapy, alcohol &/or substance abuse records which are in the possession or control of ***Hinsdale Psychiatry, S.C.***

The purpose of such disclosure is for use in connection with: Coordination of Care purposes. The information and records released pursuant to this consent will not be used for any other purpose.

I understand that I may refuse to sign this authorization to release information.

I understand that I may receive a copy of this authorization to release information.

I understand that this release automatically expires within ninety days unless I authorize the following expiration by checking the associated box below.

□ I would like this authorization to expire only once my care at Hinsdale Psychiatry, S.C. has terminated.
□ I would like this authorization to expire on the following date:______________________________

____________________________	____________________________	________________
Patient Signature (12 & up)	*Patient Name (12 & up)*	*Date*
____________________________	____________________________	________________
Representative Signature	*Representative Name (print)*	*Date*

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