

**Alliance Clinical Associates, S.C.**

7 Blanchard Circle - Suite 201  
Wheaton, IL 60189  
630-653-2300

**Authorization Form for Release of Confidential Health Information**

I, \_\_\_\_\_, hereby authorize **Alliance Clinical Associates**,  
*(Name of Patient or Authorized Agent)*

to **release** or **receive** (circle one OR both) information contained in the patient record of

\_\_\_\_\_ born \_\_\_\_\_ **to** or **from** (circle one OR both) the following:  
*(Patient's Name)* *(Birthdate)*

\_\_\_\_\_  
*(Name of Health Care Facility, Physician, Agency, etc.)*

\_\_\_\_\_  
*(Street Address, City, State and Zip Code)*

To be disclosed, the following items must specifically be checked:

- Account Information
- Hospital Reports
- Laboratory Reports
- Office Psychotherapy Notes
- Psychological Testing Report
- Treatment Summary
- Verbal Discussion of Case
- Other (specify): \_\_\_\_\_

The purpose(s) of the authorization is (are) :

- At the request of the individual
- Payment of Account
- Coordination of Psychiatric Treatment
- Other (specify): \_\_\_\_\_

- I understand that the practice may not condition treatment on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that I may be responsible for the cost of medical record copying service.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information to this Health Care Facility, Physician, Agency, etc. will terminate on \_\_\_\_\_.

*(Expiration Date)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Parent or Guardian

\*\*Patient signature is required in addition to the parent or guardian signature for patients ages 12 – 17.