Institute for Personal Development

1401 Lakewood Drive Suite A
Morris, IL 60450
P: 815-942-6323
F: 815-941-0308

1239 Windham Parkway
Romeoville, IL 60446
P: 630-226-9303
F: 630-226-9475

111 N. Wabash, Ste 1116
Chicago, IL 60602
P: 312-929-3022
F: 312-265-1638

2121 Oneida St., Ste 304
Joliet, IL 60435
P: 815-725-6511
F: 815-725-7166

Also Serving: Aurora & Ottawa

Authorization to Release Information

____ I authorize Institute for Personal Development to request records from the following office:

✓ I authorize Institute for Personal Development to release records to the following office:

RECORDS DEPOSITION SERVICE, INC.
(Name of Facility or Clinician)/Nature or Relationship to Patient

120 W. MADISON ST., SUITE 300 (Address)

CHICAGO, IL (City, State, Zip)

312-553-8900 (Phone Number)

312-553-8901 (Fax Number)

The following information on _____ _____
(Patient's Name) (Date of Birth)

Please release the following information (or specify):

___ Verbal Information
___ Medical Records
___ Medical History/Physical
___ Psychologist Evaluation
___ Social History
___ Prescription/Sample Pick-Up
___ ALL INFORMATION
___ Lab Results
___ Treatment Plan/Patient Progress
___ Discharge Summary
___ Results of Drug and Alcohol Treatment or Testing
___ Mental Health Records
✓ Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

For the Purpose of: DISCOVERY BEFORE TRIAL

Approximate Dates of Service: _____

Release Expiration Date: _____ *Not to exceed 90 days* (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.

_____ _____
Signature of Patient / Responsible Party if Minor — Date

_____ _____
Signature of Witness — Date

_____ _____
Signature of Clinician #1 — Date

_____ _____
Signature of Clinician #2 — Date

_____ _____
Signature of Clinician #3 — Date

**** There is a standard processing fee of $30.00 for any medical records that are released.*
*All patients 12 years of age or older need to sign this authorization to release. ****

Updated: 12/2014