Palos Medical Group Behavioral Health – Consent for Release of Information

From: PMG Behavioral Health
12255 S. 80th Ave #202
Palos Heights, IL 60463

Name: _____

D.O.B: _____

Having been fully informed of the circumstances in connections with this request, I hereby request and authorize you to disclose the following information* in your record of services to me (or my child, _____) to:

_____ Admission Information
_____ Discharge Information/Summary
_____ Medication Records
_____ Physical Examination
_____ Medical History
_____ Social History
_____ Psychological Evaluation/Testing
_____ Psychiatric Evaluation
_____ Insurance Disability Reports
_____ Substance Abuse History
_____ Treatment (Progress Notes)
__X__ Other: Please see enclosed Subpoena or Letter Request for information to be disclosed.
(Specify)

To: **RECORDS DEPOSITION SERVICE, INC.**
Name
120 W. MADISON STREET, STE. 300
Address
CHICAGO, IL 60602
City State Zip
312-553-8900
Phone
312-553-8901
Fax

Type of information to be released: medical, psychiatric, psychological records or evaluation and/or treatment for physical and/or emotional illness including past history, diagnosis, complications and residuals, prognosis, progress notes, medication, IQ scores, treatment plans, recommendations, summaries, evaluations and treatment records of alcohol or drug abuse, records of HTLV-III or HIV testing (AIDS test) results and AIDS treatment.

I hereby have the right to inspect and copy the information to be disclosed. The consequences of refusal to consent are: **no release of information**

The purpose for this disclosure is: **FOR DISCOVERY BEFORE TRIAL**

It is understood that this authorization is subject to revocation by me at any time in writing except to the extent that actions has been taken to release this information. This authorization shall remain valid until revoked and will expire in one year (365 days) after signing.

NOTICE TO RECEIVING AGENCY/PERSON:
Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and Federal Regulations (42 CFR Part 2), you may not redisclose any of this information unless the person who consented to such redisclosure

X _____
Minor Signature (12 – 17 years old)

X _____
Client of Person authorized to sign in case of Minor (12 – 17 years old) or incompetent

X _____
Date

X _____
Witness