YOU
PSYCHIATRY CLINIC

BE WELL, BE YOU
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AUTHORIZATION FOR RELEASE OF PATIENT HEALTHCONFIDENTIAL INFORMATION (ROI)

INSTRUCTIONS
This form authorizes the release of your healthcare information. It must be fully completed, signed, and witnessed. Fax or email the completed form to the contact information listed below.

PATIENT INFORMATION		
First Name: Middle: Last:		
Date of Birth (MM/DD/YYYY) / /	Phone Number: ( )	
Street Address:		
City:	State:	ZIP code:

HEALTH INFORMATION REQUESTED FROM:		
I, (Patient's Full Name) _____, authorize YOU Psychiatry Clinic to release the following mental health-related information: (Patient must initial and date below for each item approved for release)		
Genetic Testing - GeneSight®	Initial:	Date:
Genetic Testing - Tempus	Initial:	Date:
Drug/Alcohol Information	Initial:	Date:
HIV Information	Initial:	Date:
Entire Mental Health Record	Initial:	Date:
Developmental Disabilities	Initial:	Date:
Initial Psychiatric Evaluation	Initial:	Date:
Psychiatric Progress Notes	Initial:	Date:
Psychiatric Discharge Summary	Initial:	Date:
Diagnostic Evaluation Report	Initial:	Date:

ADDITIONAL INFORMATION TO BE RELEASED:

- ☐ Medical Record/Information
- ☐ Laboratory Results
- ☐ EKG Results
- ☐ Other (please specify): _____

RELEASE REQUESTED MEDICAL INFORMATION TO

(Requestor may be billed unless it is a medical or therapy office for the continuation of care)

☐ Check if the information is being released to the patient (self). If **not**, please fill out below

Individual or Organization's Name:		
Street Address:		
City:	State:	ZIP code:

PURPOSE:

The information above is being released for the following purpose(s):

- ☐ Continuation of Care
- ☐ Personal Records
- ☐ Insurance
- ☐ Legal
- ☐ Other (please specify): _____

DURATION OF AUTHORIZATION

(Please only check one of the following boxes)

☐ This authorization shall remain in effect for the duration of the patient's treatment, or until revoked in writing by the patient. A revocation will not affect any disclosures made prior to the receipt of the written notice of revocation

☐ Date: From _____ /_____/_____ To _____ /_____/_____

IMPORTANT NOTICE

This authorization is governed by the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), the Illinois Code of Civil Procedure (735 ILCS 5/8-2001), the Employee Personnel Records Act (820 ILCS 40/0.01), and the Health Insurance Portability and Accountability Act (HIPAA), as applicable.

This authorization is voluntary. By signing this form, I hereby authorize YOU Psychiatry Clinic to use and/or disclose my Protected Health Information (PHI) as outlined above for the specific purpose described. I acknowledge that my decision to provide this authorization is entirely voluntary, and I am giving my consent to allow the clinic to share my PHI as per the details provided. I understand that if the individuals or organizations receiving my PHI are not subject to federal health information privacy laws, they may further disclose my PHI, which may no longer be protected under such laws.

I also recognize my right to inspect and copy the information that will be disclosed under this authorization. Should I wish to obtain a copy, I may do so by contacting the clinic as listed above. I am aware that I may revoke this authorization at any time by submitting written notice of my revocation to the clinic.

I confirm that I have had the opportunity to thoroughly review and consider the contents of this authorization. By signing this form, I provide my informed consent for YOU Psychiatry Clinic to use and/or disclose my PHI to the individuals and/or organizations specified above.

SIGNATURES

Patient/Representative Signature:	Date: / /
If signed by Representative, Name:	Relationship to Patient:

Witness Signature:	Date: / /
Witness Name:	Relationship to Patient:

CONFIDENTIALITY NOTICE

This document, including any attachments, is the property of YOU Psychiatry Clinic and is intended solely for the designated recipient(s). Unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, delete this document and notify the sender immediately.