Decatur Psychological Associates, P.C.
3040 N. University Ave., Ste 2
Decatur, IL 62526
217-872-1700 Phone
217-872-1366 Fax

Name ______________________ Date of Birth __________ SS# ______________

Address ____

Hereby REQUEST and AUTHORIZE Decatur Psychological Associates, P.C. to release/obtain the following information pertaining to my Substance Abuse and/or Mental Illness:

Check		Initial	Check		Initial
____	Medical History	____	____	Financial History	____
____	Diagnosis & Prognosis	____	____	Substance Use History	____
____	Social History	____	____	Legal History	____
____	Psychiatric History	____	____	Mental Health Assessment	____
____	Psychological History	____	____	Personal History	____
____	Treatment Plan	____	____	Educational History	____
____	Summary	____	____	Other (specify)	____
____	Laboratory Reports	____	____	All Information	____
____	X-Ray Reports	____			
____	Operative Notes	____			
____	Progress Notes	____			

Release to / obtain from:

(Name of Physician, Health Care Facility, Agency Etc.) ______________________

____
(Address) (State) (Zip)

( ) ______________________ ( ) ______________________
(Phone) (Fax)

The above information for the following period of time shall be released: From:______________ To: ______________.

Purpose of Disclosure: **Continuum of Care**

This information is being disclosed from records whose confidentiality is protected by one of the following state or federal laws. State law and federal regulation (42 CFR part 2) and mental health and developmental disabilities confidentiality act (ILL. Rev Sate 1991. ch91 1/2 Par 801 ct seq.) which prohibits the redisclosure of any general authorization for the release of medical or other information is not sufficient for this purpose. I understand that I have the right to inspect and receive copy of the information that is disclosed.

I understand that I can revoke this consent in writing at any time except as to disclosures already made. Unless revoked, this consent to release will expire on year from the date signed on ___________________. This is a continuing disclosure which covers the entire treatment episode and until all claims are filed and processed.

I attest to the Identity of Signatory (is) below:

______________________ ______________________ ______________________
Guardian Signature Date Date Sent/Initial

______________________ ______________________ ______________________
Patient Signature Witness Signature Therapist/Doctor Signature

*** If the Patient is 13 years or older they MUST also sign the consent***