CONVENTIONS
PSYCHIATRY & COUNSELING
4300 Weaver Parkway, Suite 100-A
Warrenville, IL 60555
Phone: (630) 416-8289 Fax: (630) 416-8306

Authorization to Release Medical Information

First Name _____ Last Name _____ M.I. ____ Date of Birth _____

I, hereby authorize: Conventions Psychiatry and Counseling

To release information to:

Name _____
Address _____
Phone _____
Fax _____

To obtain information from:

Name _____
Address _____
Phone _____
Fax _____

Information to be released:

- □ All psychiatric treatment: □Psychiatric evaluations □ Progress notes □ Medications □Lab results □Verbal communication
  From _____ through _____ (Dates)
- □ Psychological or neurological test results
- □ Hospital reports (History & Physical, discharge summary, etc.)
- □ Coordination of care
- □ Other (Specify materials to be released): _____

This authorization is valid for 365 days from the date below. I understand that I can withdraw this consent at any time by submitting a written request. This information is confidential and further disclosure by the receiving party is prohibited without written consent. I have read and understand the above statement. I release Conventions Psychiatry & Counseling of all legal liability that may arise from this disclosure.

_____
Patient/Legal Guardian Signature Date

_____
Witness (Print) Date

At this time, I refuse the Authorization to Release Medical Information form.

_____
Patient/Legal Guardian Signature Date