Authorization to Release Information- Part 1

Client Name:______________________________________ DOB:_________________________

Address:____ Phone:_________________________

Purpose of Release:
This release is to authorize IAG Behavioral Health Center and an outside provider to release information to each other in order to provide quality services and continuity of care for the client named above.

I hereby authorize: **To:**

IAG Behavioral Health Center 30 Phelps Ave. Romeoville, IL 60446 Phone: 630-755-0053 Fax:630-755-0054	☐ Release Information to: ☐ Obtain Information from: ☐ Exchange information with:	**Name:** _________________________ **Address:** _________________________ _________________________ **Phone**: _________________________

Information to be released:

- ☐ Physician orders
- ☐ Medication administration records
- ☐ Lab results
- ☐ Treatment records
- ☐ Social history
- ☐ Psychological evaluations
- ☐ Psychotherapy notes
- ☐ Insurance cards/information
- ☐ Other ____

Authorization:
This voluntary information release is authorized on _______________________ (today's date) and is valid for one year, unless otherwise revoked.

I understand that failure to sign this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

_______________________ _________________ ___________________ ______ _____
Client / Guardian Signature | Print Name | Relationship to client | Date | Time