***Summit Clinical Services***
***1761 S Naperville Road, Suite 200***
***Wheaton, IL  60189***
***Phone:  (630) 260-0606***
***Fax:  (630) 260-1049***

Patient Name: ______________________________
Address: ____________________________________
____________________________________________
Phone #: (_____) _______ - _____________
Date of Birth: ______________________________

# AUTHORIZATION TO RELEASE/SECURE INFORMATION

I, ________________________, authorize Summit Clinical Services to:
(Name of Patient or Authorized Agent)

Release to / Secure from:

________________________________________________
Name
________________________________________________
Address
________________________________________________
City State Zip
________________________________________________
Fax Number
________________________________________________
Phone  Number

The following information:

_____ Admission Summary
_____ Discharge Summary
_____ Lab Reports
_____ Office Psychotherapy Notes
_____ Psychologist Test Report
_____ Treatment Summary
_____ Copy of All Psychiatric Chart Records
_____ Other (specify)_________________________

The purpose of this release of information is to:

_____ Coordinate Psychiatric Treatment
_____ Other (Specify) ______________________________________________________

I understand that I have the right to inspect and copy the information being disclosed and the right to revoke this consent by written statement at any time unless action based on it has already begun.  This authorization will expire one year (365 days) from the below date.

I voluntarily consent to the release of this information to the above named person or agency.  I release the staff of Summit Clinical Services from any liability arising from the release of this information provided that the release of information is done substantially in accordance with applicable law.

________________ ____________________________________________
Date Patient Signature / Printed Name
(for patient 12 years and older)

________________ ____________________________________________
Date Parent/Guardian Signature / Printed Name
(for patient 12 to 18 years old)

________________ ____________________________________________
Date Witness Signature / Printed Name

*Notice to receiving agency/person: a patient's medical record is privileged information which is protected by State and Federal laws and may not be re-disclosed to persons or organizations without a separate written authorization from the patient.*

*updt   3/21/17*