

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

<b>Patient Name:</b> _____ <b>Address:</b> _____ _____ <b>Phone #:</b> (____) _____ - _____ <b>Date of Birth:</b> _____
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## AUTHORIZATION TO RELEASE/SECURE INFORMATION

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

➡ Release **to** / Secure **from** (circle one or both):

Name		
Address		
City	State	Zip
Fax Number		
Phone Number		

**The following, checked, information:**

- |   |  |
|---|--|
| <input type="checkbox"/> Admission Summary          | <input type="checkbox"/> Psychologist Test Report              |
| <input type="checkbox"/> Discharge Summary          | <input type="checkbox"/> Treatment Summary                     |
| <input type="checkbox"/> Lab Reports                | <input type="checkbox"/> Copy of All Psychiatric Chart Records |
| <input type="checkbox"/> Office Psychotherapy Notes | <input type="checkbox"/> 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.*