NORTHWEST PSYCHIATRY
SOUTH BARRINGTON OFFICE
10 EXECUTIVE COURT, SUITE 5
SOUTH BARRINGTON, IL 60010

PHONE: (224) 655-2487
FAX: (716) 526 4161
VISIT US ONLINE: nwpsych.us
SEND COMPLETED FORMS TO: intake@psychwebmd.com

HEALTH INFORMATION **AUTHORIZATION FORM**

AUTHORIZATION TO RELEASE AND OBTAIN HEALTH INFORMATION

I, _____ *your name* **O** Patient OR

O Authorized Agent **for** _____ *patient name*,

hereby authorize **Northwest Psychiatry** to:

O release my health information **to** the below facility/clinician

O receive my health information **from** the below facility/clinician

FACILITY/CLINICIAN NAME _____

FACILITY/CLINICIAN ADDRESS _____

FACILITY/CLINICIAN PHONE _____

FACILITY/CLINICIAN CITY/STATE _____

FACILITY/CLINICIAN FAX _____

FACILITY/CLINICIAN ZIPCODE _____

AT LEAST ONE OF THE ITEMS MUST BE CHECKED

O ACCOUNT INFORMATION
O HOSPITAL REPORTS
O LABORATORY REPORTS
O OFFICE THERAPY NOTES
O PSYCHOLOGICAL TESTING REPORT
O TREATMENT SUMMARY
O VERBAL DISCUSSION OF CASE
O OTHER: _____

THE PUROSE OF THIS AUTHORIZATION IS

O AT THE REQUEST OF THE PATIENT
O PAYMENT ON ACCOUNT
O COORDINATION OF PSYCHIATRIC TREATMENT
O DISABILITY CLAIM
O OTHER: _____

- I understand that this information may be transmitted via written word, fax, or over the phone.
- I understand authorization for this release of information can be revoked at any time.
- To revoke this authorization, I understand that I must provide a statement in writing with my request unless an expiration date is provided here: _____

PATIENT NAME _____

TODAYS DATE _____

PATIENT DOB _____

SIGNATURE OF PARENT/GUARDIAN/AUTH.AGENT _____

PATIENT SIGNATURE (required for patients' aged 12 and up) _____

SIGNATURE OF WITNESS _____