Release of Information

I request and authorize the health care professional, agency, hospital or medical center listed below to release the information specified to:

Amanda Bevacqua, LMFT
2334 W. LAWRENCE AVE, SUITE 212
CHICAGO, IL 60625
773.988.5147

Name, address, phone number and fax number of organization or individual who is to release information:
_____
_____

Information or communication requested:
_____

I also authorize Amanda Bevacqua, LMFT to provide written and/or verbal information regarding my mental health treatment to the organization or individual above, if I am currently in treatment with thatorganization or individual.

Purpose of release of information: at the request of the individual

The statutes that govern this authorization include but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/7 2001 (inspection and copyingof hospital records and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

I understand that I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing, at any time by sending such written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Refusal to sign this form will result in the following consequences: Information will not be disclosed/obtained.

It is my full understanding that the records and communications disclosed WILL include sensitive information such as evaluation, treatment for mental health, developmental disabilities, alcohol or substanceuse/abuse or HIV/AIDS unless specifically checked below for exclusion:

___ Alcohol/Substance Abuse ___ HIV\AIDS ___ Mental health ___ Developmental disabilities
___ Other: _____

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may have a copy of this form at any time that I choose to request it. The authorization will automatically **expire in one year from the date of signature** or, if I prefer, on the date specified here: _____

_____ _____
Full Printed Name of Patient Date of Birth

_____ _____
Signature Date