



Authorization for Release of Information

I, _____ whose Date of Birth is ____/____/____, authorize Live Oak, Inc. to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Educational Information | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Psychological Assessment | <input type="checkbox"/> Current Treatment Update |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Medical Information |
| <input type="checkbox"/> Nursing Information | <input type="checkbox"/> Toxicological Reports/Drug Screen | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psychiatric Report | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If there is another purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Live Oak, Inc., 1300 W. Belmont, Suite 400, Chicago, IL 60657. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: 12/31/08 or as otherwise indicated: _____

If a calendar date is not stated, information may only be released on the date the authorization is received.

Conditions

I further understand that Live Oak, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date