NYE LAW GROUP LTD.

FAMILY LAW - MENTAL HEALTH - HUMAN SERVICES

200 OPATRNY DRIVE
FOX RIVER GROVE, IL 60021

DOWNTOWN CHICAGO
BY APPOINTMENT

VALID MENTAL HEALTH CONSENT CHECKLIST

The release must contain ALL of the following components:

1. Is the person authorizing a person who is designated under Section 5 (740 ILCS 110/4) of the Confidentiality act?
2. Is the person or agency to whom disclosure is to be made identified?
3. Is the purpose for which disclosure is to be made identified?
4. Is the specific nature of the information to be disclosed identified?
   a. Are the check box checked for all types of data to be disclosed?
   b. Are the blank lines next to the check boxes initialed for all types of data to be disclosed?
5. Does the release identify that there is a right to inspect and copy the information to be disclosed?
6. Does the release provide for the consequences of a refusal to consent, if any?
7. Is there a calendar date on which the consent expires, provided that if no calendar date is stated, information may be released only on the day the consent form is received by the therapist?
8. Is there a right to revoke the consent at any time provided?
9. Is the consent form signed by the person entitled to give consent?
10. Is the signature witnessed by a person who can attest to the identity of the person?

If any above element is missing the release is fatally flawed.

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____, hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange\release any and all records or information regarding _____
(Name of Patient)

_____
(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ ____ HIV / AIDS related treatment ☐ ____ Mental health information ☐ ____ Psychotherapy notes

☐ ____ Sexually transmitted diseases ☐ ____ Drug/alcohol diagnosis, treatment/referral.

to _____ _____
(Receiving Agency/person) (Address)

For the purpose of: (please check all that apply)

☐ Continuing (health and mental health) treatment or care and continuity of care

☐ Therapist transition

☐ Housing and other arrangements and services

☐ Billing, payment and financial matters and arrangements

☐ Consultation, advise and representation regarding my condition and needs

☐ Other _____
_____

This consent is valid until **(calendar date)** _____
I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____
_____

_____ _____ _____
(Minor recipient, 12-17 yrs. Inclusive) (Signature of adult patient or parent) (Date)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____ _____
(Patient, parent, guardian) (Witness)

_____ _____
(Authorized agent - Power of attorney attached) (Date)