Authorization to Release Confidential Information

I hereby authorize:

INSIGHT THERAPEUTICS – Winfield
27 W. 140 ROOSEVELT ROAD, SUITE 205
WINFIELD, IL 60190

INSIGHT THERAPEUTICS – Northbrook
350 PFINGSTEN ROAD, SUITE 110
NORTHBROOK, IL 60062

P: (847) 800-9347 F: (847) 628-0791

To use or release health information and records obtained during the course of treatment of:

Client Name: _____ **DOB:** _____

The information to be used or disclosed includes only items indicated below, with respect to services provided (insert specific dates of service): _____.

This information should be (Check ONLY one):

☐ RELEASED TO ☐ RECEIVED FROM ☐ EXCHANGED WITH

The following person/s or organization:

Person/Organization:_____

Address: _____

Phone:_____ **Fax**: _____

I understand that this authorization includes all of the indicated information below, which includes treatment for physical or mental illness, substance use or abuse, HIV/AIDS status information, and any assessment or test results and diagnoses. **Information to be released includes**:

- ☐ Client Demographic Information
  (Name, DOB, Address, Phone and Guardian Demographic Information in the Event of Dependent Client Status)
- ☐ Dates of Service, Including Attendance, Progress, and Participation in Treatment
- ☐ Biopsychosocial Assessment
- ☐ Specific Diagnosis Information
- ☐ Status or Involvement of Psychiatric Care
- ☐ Medical Health and Medication Management Information
- ☐ Drug Screen Results
- ☐ Educational Information (Includes Attendance, Progress, Concerns, and Special Education Records/Information)
- ☐ Discharge Summary and Recommendations, Including Continued Care Plan and Referrals Provided

☐ Entire Record MUST INITIAL: Client Initial: _____Parent/Guardian Initial: _____Witness Initial:_____

☐ Information from other sources, such as previous therapists, school records, or other information contained in the clinical file

☐ Other (Describe: _____)

Insight Therapeutics, Inc.
HEALING FROM WITHIN

PURPOSE AND CONSEQUENCES

This Release of Information is to provide continuity of care, assessment, and treatment planning for the aforementioned client. This Release of Information is also in place to provide continuity and coordination of care. If for another purpose, specify: _____ . It has been explained to me that failure to sign this authorization may have the following consequences: _____.

REVOCATION

You have the right to revoke this Release of Information at any time without consequence from your therapist. To do so, you must provide NOTIFICATION IN WRITING to: Insight Therapeutics, Privacy Officer, 27 W. 140 Roosevelt Road, Suite 205, Winfield, IL 60190-1642, Fax: (847) 628-0791. Revocation of this Release is not effective to the extent that information may have been shared prior to its revocation.

EXPIRATION

Unless revoked in writing, this Release of Information expires on: _____. If no date is specified, this Release of Information is valid ONLY on the date it is received by Insight Therapeutics.

FORMS OF DISCLOSURE

Unless otherwise specified in writing, we reserve the right to disclose information permitted by this authorization including verbally, in writing, or electronically.

RIGHT TO ACCESS OF INFORMATION

I understand that I am entitled to inspect and copy (at cost) information disclosed in the context of this Release of Information. I also understand that I am entitled to a copy of this Release of Information form.

REDISCLOSURE

The party releasing information cannot re-release information not created by that party. For example, if you provide a medical report from another provider, Insight Therapeutics cannot send that school documentation to another party because it was not created by anyone at Insight Therapeutics. State and Federal law prohibit the re-release of information (Exceptions permitted by 42 C.F.R. Part 2 of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 1 10/1 et. Seq.)) Signing this document indicates that you understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.

Client Signature (Age 12 and older):_____Date of Signature: _____

☐ Client is under age 12 at time of signature. Date client will turn age 12: _____

Parent/Guardian Signature: _____Date of Signature: _____

Relationship of Parent/Guardian (Check one):

- ☐ Biological or Adoptive Parent
- ☐ Legal Guardian
- ☐ Power of Attorney
- ☐ DCFS Authorized Agent
- ☐ Other: _____

Staff/Witness Signature: _____ Date of Signature: _____