Edgewood
A LIFESTANCE HEALTH COMPANY

# CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

My health record is private and is known under the law as "Protected Health Information" (PHI). By completing and signing this form, I, or my legal representative, agree to allow Edgewood to share my PHI with the people or companies listed below.

**1. Client information**

| | | | |
|---|---|---|---|
| CLIENT FIRST NAME | | CLIENT LAST NAME | |
| STREET ADDRESS | | CITY | STATE |
| BIRTHDATE | PHONE # | RELATIONSHIP TO CLIENT | |

**2. I authorize the Protected Health Information of the above named person to be exchanged between:**

| **FROM:** | **TO:** |
|---|---|
| PERSON OR COMPANY | PERSON OR COMPANY |
| STREET ADDRESS | STREET ADDRESS |
| CITY, STATE, ZIP | CITY, STATE, ZIP |
| PHONE NUMBER | PHONE NUMBER |

**3. Method of Delivery (choose one)**

| | | | |
|---|---|---|---|
| ☐ USPS Mail | ☐ Fax | ☐ Telephone: | ☐ Email: |
| ☐ Pick Up (please specify location) | ☐ South Naperville | ☐ North Naperville | ☐ Lisle ☐ Plainfield |

**DISCLAIMER:** When an email is sent or received, the information that is included in that email is not encrypted. This means that a third party may be able to access the information and read it while it is transmitted over the internet. In addition, once the email has been received, someone may be able to access your email account and read that email. HIPAA does not require the use of encrypted email if the patient has been made aware of the risks of unencrypted email and that patient has provided authorization to receive protected health information (PHI) via email. By providing an email address, I acknowledge that I understand the risks of unencrypted email and give my permission to Edgewood Clinical Services to send my Personal Health Information (PHI) via unencrypted email.

**4. Edgewood can share ONLY my records chosen below. (initial all that apply)**

_____ Assessment, Treatment Plan, and/or Clinical Summary Initial
_____ Psychological Evaluation Report Initial
_____ Psychiatric information/notes Initial
_____ Financial Information Initial
_____ Other: Please Specify _____ Initial

**5. Dates of records to be disclosed:** **FROM:** _____ **TO:** _____

**6. Edgewood is sharing/receiving this information for the following purposes: (initial all that apply)**

_____ Continuity of Care Initial
_____ Personal Use Initial
_____ Attorney/Court Initial
_____ Financial/Benefits Initial



Revised
10/18/19

I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider or healthcare plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations. I understand that I may revoke this authorization at any time; however, the revocation must be in writing, sent or given to the HIPAA Compliance Officer at Edgewood. As pursuant to Illinois law, information used or disclosed through this authorization may not be further disclosed to a third party without an additional signed consent form. Refusal to sign this form will not prevent treatment, payment or eligibility for benefits. ***It is our policy to not release psychotherapy notes or substance abuse and treatment records without your consent unless required by insurance or court order.***

This form will be valid for **one year** from the date of signature or until _____ whichever comes first.
**Specified Date**

| | |
|---|---|
| CLIENT SIGNATURE (OVER 12) | DATE |
| PRINT NAME | |
| PARENT/GUARDIAN SIGNATURE (UNDER 18) | DATE |
| PRINT NAME | |
| If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney) | |
| WITNESS SIGNATURE | DATE |

**Please return this complete form to:**

HIPAA Compliance Officer
**Phone:** 630.428.7890 **Fax:** 630.428.7891
**Email:** records@edgewoodclinicalservices.com