Edgewood

CONSENT FOR RELEASE OF INFORMATION INSTRUCTIONS

In order to process your medical records request, you will need to complete the attached Consent for Release of Information form. Below are instructions on how to complete the form.

1. **Client Information**
    a. This information should be the information for the person the records are being requested for
    b. If you are submitting this request on behalf of the client, your name and your relationship to the client should be listed below the client's information.
2. **Authorization**
    a. Select if you want Edgewood to SHARE or RECEIVE your records/information.
        i. SHARE = Edgewood will send your records to the person or company you list on the form
        ii. RECEIVE = Edgewood will request your records from the person or company you list on the form
    b. List the person or company you want your records/information to be shared with or requested from
3. **Method of Delivery**
    a. Select which method(s) of delivery you want Edgewood to use when sending or requesting your records/information.
        i. Preferred Methods
            1. USPS Mail
            2. Fax
            3. Pick Up
        ii. Telephone is used for VERBAL communication only
        iii. Email will **only** be used in very special circumstances
4. **Type**
    a. Select carefully which types of records you want Edgewood to send or request.
5. **Dates of Services**
    a. Select which dates of service you want Edgewood to send or request.
        i. EXAMPLE – If you were seen at Edgewood from 01/2014 – 05/2019, you can request records from any date range within that time frame. Please be specific.
6. **Purpose**
    a. Select the reason you are asking for Edgewood to send or request your records/information.
        i. EXAMPLE – sending records to your new doctor would be considered "continuity of care"; sending records to social security administration for disability benefits determination would be considered "financial/benefits".
7. **Expiration Date**
    a. This form will automatically be valid for one year from the date of signature UNLESS you specify otherwise. **You do not have to put a date here unless you want to.** If you do not supply a date, the form will expire in one year. DO NOT USE TODAY'S DATE IN THIS FIELD.
8. **Signatures**
    a. If the client that records are being requested for is age 12 to 17 years old, **they must sign the consent for release of information form along with their parent or guardian**
    b. If the client that records are being requested for is under the age of 12, only the parent or guardian will sign.
    c. If the client that records are being requested for is age 18 years old or older, they will sign the form themselves.
    d. A witness signature is required the mental health medical record requests.
        i. If you are completing this form in the office, the front desk staff or your clinician can sign as the witness.
        ii. If you are completing this form at home someone, other than yourself, who can attest to your identity can sign as the witness.

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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 #	

PERSON COMPLETING THIS FORM (IF DIFFERENT FROM CLIENT)	NAME	RELATIONSHIP TO CLIENT

2. I authorize Edgewood Clinical Services to (check <u>all that apply</u>) the above client's protected health information with the following:

☐ **SHARE** ☐ **RECEIVE**

PERSON OR COMPANY
STREET ADDRESS
CITY, STATE, ZIP
PHONE NUMBER
FAX

3. Method of Delivery (choose all that apply)

☐ USPS Mail	☐ Fax:	☐ Telephone: ****VERBAL COMMUNICATON ONLY****	☐ 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. Select which <u>TYPES</u> of records you want to be released. (initial all that apply)

_____ **Counseling Assessment/ Treatment Plan**
Initial

_____ **Psychiatric Treatment/ Medication Notes**
Initial

_____ **Verbal Communication Only**
Initial

_____ **Psychological Evaluation Report**
Initial

_____ **Financial Information**
Initial

_____ **Clinical Case Summary**
Initial

_____ **Other: Please Specify** _____
Initial

5. List which <u>SERVICE DATES</u> you want to be released: **FROM:** _____ **TO:** _____

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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

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.***

7. This form will be valid for **one year** from the date of signature or until _____ whichever comes first. **(Please do not use today's date)**
Specified Date

8. **Clients 12 years and older must consent to this request by signing below along with their parent or guardian**

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:

Edgewood Medical Records Department
Phone: 630.428.7890 **Fax:** 630.428.7891
Email: records@edgewoodclinicalservices.com