



**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)**

<input type="checkbox"/> USPS Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Telephone:	<input type="checkbox"/> Email:
<input type="checkbox"/> Pick Up (please specify location)	<input type="checkbox"/> South Naperville	<input type="checkbox"/> North Naperville	<input type="checkbox"/> Lisle <input type="checkbox"/> 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)**

<input type="checkbox"/> Assessment, Treatment Plan, and/or Clinical Summary	<input type="checkbox"/> Psychological Evaluation Report
Initial _____	Initial _____
<input type="checkbox"/> Psychiatric information/notes	<input type="checkbox"/> Financial Information
Initial _____	Initial _____
<input type="checkbox"/> 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)**

<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Attorney/Court	<input type="checkbox"/> Financial/Benefits
Initial _____	Initial _____	Initial _____	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.***

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](mailto:records@edgewoodclinicalservices.com)