Metropolitan Family Services

CONSENT FOR RELEASE OF INFORMATION

I have been informed of my rights concerning the release of confidential information and give my permission for Metropolitan Family Services to: _____ receive _X_ provide _____ verbal information _X_ written information to / from:

RECORDS DEPOSITION SERVICE, INC.

120 W. MADISON ST., SUITE 300, CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901

(Name and address of Agency, Physician, Clinician, Individual)

the following information:

☐ Diagnosis ☐ Treatment Summary ☐ Attendance ☐ Mental Status Exam

☐ Recommendations ☐ Progress ☐ Physical Examination ☐ Medication ☐ Prognosis

☐ Discharge Summary ☒ Other SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

about me or my child_____

(Name and date of birth)

for the purpose of: FOR DISCOVERY BEFORE TRIAL

_____ Dates of service if requesting records: _____ - _____

SPECIFIC AUTHORIZATION FOR RELEASE OF ADDITIONALLY PROTECTED INFORMATION

I understand that the information may include, when applicable, information relating to sexually transmitted diseases, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by CFR Part 1)

I specifically authorize the release of data and information relating to:
(Client, parent or guardian must initial item to be released)

_____ HIV/AIDS related information and/or records

_____ Mental health information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Describe info to be disclosed)
(_____)

This information is not to be exchanged with any other agency/institution/or individual without my signed consent.
I understand that:

My refusal to consent may hamper or prevent Metropolitan Family Services' ability to provide services in the following way(s):_____

I have the right to inspect and copy the information to be disclosed by Metropolitan Family Services prior to disclosure.

Permission is valid until the stated date for a period of time appropriate for typical service information and correspondence needs and no *longer than one year*: _____

(End of Consent Date)

(note: if no end of consent is entered the release is valid only for the single) day that it is signed)

IMPORTANT: Client, Parent or Guardian please initial that you have read this first of two pages: ☐

I may withdraw this authorization at any time.

I understand that Metropolitan Family Services cannot guarantee the recipient receiving the requested health information will not redisclose any or all of it to others. If the person or entity receiving the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

SIGNATURE(S) OF CLIENT, PARENT OR GUARDIAN:
(minor must sign if 12 or older)

_____ Date: _____

_____ Date: _____

_____ Date: _____

Witnessed by: _____
(Name and Relationship) (Date)

NOTICE: No person or company to whom any information is disclosed pursuant to this authorization may redisclose such information unless the person who authorized this disclosure specifically consents to such disclosure.

NOTE TO RECEIVING AGENCY/PERSON: This information has been disclosed to you from records protected by Federal confidentiality rules under HIPAA (45 CFR, 160 & 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State law under the Mental Health & Developmental Disabilities Act (740 ILCS 110) regarding the confidentiality of mental health records also prohibits redisclosure of this information without the specific consent of the person who consented to the disclosure.

REVOCATION: As of this date, I hereby revoke the consent provided on this authorization form.

_____ _____
Signature Date

_____ _____
Witness (who can attest to the identity of the signatory) Date

SPECIAL INSTRUCTIONS: The client must receive a copy of this document and the original must stay in the client record in accordance with state and federal laws.