James Chmielewski
1010 Lake Street
Suite 502A
Oak Park, IL 60301
(773) 430-9519

Client's Name: ______________________ Birth Date: ______________________

I hereby authorize James Chmielewski to:

☐ Release to ☐ Obtain From ☐ Both Release and Obtain from:

______________________ ______________________

Agency/Person: Address:

the information that is checked ☐ below:

☐ 1.) Diagnosis and Treatment Information: ______________________

☐ 2.) Medical information: ______________________

☐ 3.) Psychiatric/Psychological/Therapist Reports: ______________________

☐ 4.) Education: ______________________

☐ 5.) Social History Assessment: ______________________

☐ 6.) HIV/AIDS Related Information: ______________________

☐ 7.) Genetic Testing Information: ______________________

☐ 8.) Alcohol and/or Drug Abuse Patient Information: ______________________

This information is disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit 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.

☐ 9.) Other: ______________________

THE PURPOSE FOR REQUESTING THIS INFORMATION:

☐ Treatment Planning & Treatment ☐ Coordination of Services ☐ Payment
☐ Pre-Admission Evaluation ☐ Other ☐ Health Care Operations

I understand that, if the persons, or organizations I authorize below to receive and/or use the protected health information subject to this authorization are not health plans, covered health care providers, or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. **However, any mental health, alcohol and substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be redisclosed except pursuant to my authorization.**

I request the following restrict to the use, or disclosure of my protected health information:

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It is understood that the person authorizing release of this information has the right to inspect and copy the information to be disclosed and that this information will not be redisclosed without specific authorization.

The consequences, if any, of not signing this release are: Information can not be used in treatment.

This consent is valid until ________________________ and may be revoked with written consent at any time except to the extent that action has already been taken.

Signed: ______________________________ _______________
Parent or Guardian Date/Year

Signed: ______________________________ _______________
Signature of person 12 years , or older Date/Year

Signed: ______________________________ _______________
Witness Date/Year