



A Division of the Center for Rural Psychology

P.O. Box 8071, Elburn IL 60119

T:630/365-0899 F:630/365-9150

AUTHORIZATION TO COMMUNICATE WITH PHYSICIAN

At Heartland we attempt to understand the individuals we work with in a holistic manner that considers all aspects of the person. A part of this involves working with medical professionals. We highly value working as a team with medical professionals to ensure that we are aware of any medical difficulties and how these difficulties may be impacting your mental health. This form when completed and signed by you, authorizes me to receive information from your physician and release protected information from your clinical record to your physician.

Yes. You may communicate about my treatment with the physician listed below.

No. You may not share information about my treatment

Physician _____ Phone _____

Address _____

This authorization shall remain in effect for one year unless otherwise specified. If you would like to specify another date, please fill in expiration date: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

X _____
Signature of Patient (age 12 or over)
or representative*

Date

Printed Name of Patient

X _____
Signature of Witness

Date

*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Notice to receiving agency/person: Under Illinois and federal law you may not redisclose any of this information unless specifically authorized by above responsible party