Susan Myket, Ph.D. & Associates

Using Research-Supported Therapies to Enrich Families

Authorization Form

This form when completed and signed by you, authorizes me to release and receive protected information from your clinical record to and from the person you designate.

I authorize _____ to **release** and **receive**
(Name of Specialist)

information from the clinical record of _____.
(Name of Client) *(Birthdate)*

This information should only be **released to** and **received from**

_____
(Name of Health Care Facility, Physician, Teacher, Social Worker, Etc.)

_____.
(Address, Phone Number, Email)

I give those named above permission to use unsecured email as a means of communicating information from my clinical record. I acknowledge that email is not a secure form of communication and my confidentiality cannot be guaranteed. I understand that when possible, documents will be password protected or encrypted when sent via unsecured email**.** ◯ **YES** ◯ **NO**

To be disclosed, the following items must be checked:

- ☐ Hospital Reports
- ☐ Office Progress Notes
- ☐ Psychological Testing Reports
- ☐ Treatment Summary
- ☐ Verbal Discussion of Case
- ☐ Other_____

The purpose(s) of this authorization is(are):

- ☐ At the Request of the Individual
- ☐ Coordination of Psychological Treatment
- ☐ Other_____

This authorization will remain in effect until _____ (if no calendar date is stated, information may be released only on the day the form is received by the specialist).

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that the specialist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my specialist 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 & copy the disclosed mental health information at any time.
- I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

_____

Signature of Client – Age 12 and older Date

_____

Signature of Parent/Guardian if applicable 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.

1415 Bond Street, Suite 127, Naperville, Illinois 60563
Phone: (630)355-9002 Fax: (630)355-9012
www.myketandassociates.com

Signer's Identity Verified ☐
Copy Given to Client ☐