

Neal B. Strom & Associates, Ltd.
180 North LaSalle St., Suite 2510
Chicago, IL 60601
(312) 609-0400
(312) 609-0578 (Fax)

**AUTHORIZATION FOR THE RELEASE
OF PATIENT HEALTH INFORMATION**

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

hereby authorizes the provider: _____

to release to: **NEAL B. STROM & ASSOCIATES, LTD.**, 180 N. LaSalle Street, Suite 2510, Chicago, IL 60601.
Specific patient health information to be released:

Purpose of this authorization:

Expiration: This authorization will expire 90 days from (note date below) or as otherwise specified:

Right to Revoke: You may revoke this authorization at any time by giving written notice of your revocation to the provider. Your revocation of this authorization will not affect any action _____
_____ (name of provider) took in reliance on this authorization before it received your written notice of revocation.

Effect of Granting this Authorization: This authorization is voluntary. We will not condition any treatment on your willingness to sign this authorization. If the patient health information described above is authorized by you to be disclosed to persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the patient health information, and it may no longer be protected by federal health information privacy laws.

Individual's Signature:

I have had full opportunity to read and consider the contents of this authorization and I am confirming my authorization of the use and/or disclosure of my patient health information, as described in this form.

Date

Patients Signature

Personal Representative's Name (if signing on behalf of patient)

Relationship to Patient

NOTICE TO RECEIVING AGENCY/PERSON

Mental Health Records: Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act (740 ILCS 110 *et seq.*), you may not disclose any information subject to the Act unless the person who consented to this disclosure specifically consents to its redisclosure.

Alcohol and Drug Abuse Patient Records: This information has been disclosed to you from records protected by Federal Confidentiality Rules 42 CFR Part 2). The Federal Confidentiality 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 Confidentiality Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.