30 N Michigan Ave Suite 2029
Chicago, IL 60602
P: 855-COGWELL (855-264-9355)
F: 855-792-0240
www.cogwellness.com
info@cogwellness.com

Authorization to Release Health Information

Date _____

I authorize _____to (both) obtain / release the following information:
(Facility/Clinician)

_____
(Nature of Information to be Disclosed)

concerning_____,
(Patient Name) (Date of Birth)
to / from:

Provider/Family Members Name: _____

Facility (if applicable): _____

Address: _____

Phone Number:_____

Fax:_____

I understand that I have the right to inspect and copy all information to be disclosed, except to the extent not allowed by the Illinois Mental Health Code. I understand that I may revoke this authorization at any time except to the extent that action has been taken on this authorization. I further understand that this authorization shall expire without my express revocation on: _____.

I further understand that the agency or individual which receives this information, in accordance with State/Federal laws should not disclose information without further consent. The Chicago Center for Cognitive Wellness cannot guarantee that agencies or individuals receiving this information will act in compliance with these laws. Minors between the ages of 12 through 17 are requested, along with their parents, to provide consent by signing this form.

Without duly authorized consent no records can be released.

_____ _____ _____
(Signature of patient or authorized legal guardian) (Date) (Relationship, if authorized representative)

_____ _____
(Authorization to fax records) (Date)

_____ _____ _____
(Witness) (Date) (Relationship to patient)