ProActive Behavioral Services

215 North Main, Algonquin, IL 60102 **(P) 224-678-9493 (Fax) 224-678-9033**
1644 Colonial Parkway, Inverness, IL 60067 **(P) 847-776-4500 (Fax) 847-776-4724**

Authorization for Release/Exchange of Confidential Information

I, ________________________, whose social security number is ___________________ and date of birth is _________________, authorize Proactive Behavioral Services to disclose to and/or obtain from :

Agency:___________________________________ Contact Persons:____

Address:___________________________________ Phone:______________________ Fax:_________________________

Information to be Disclosed:

Item	Y	N	Item	Y	N
Assessment Summary & Recommendations			Nursing/Medical Information		
Diagnostic Summary & Diagnosis			Drug Screens		
Psychiatric Evaluation			Educational/Academic Information		
Psychological Testing Results			Discharge/Transfer Information		
Treatment Plan/Treatment Plan Reviews			Continuing Care Plan & Recommendations		
Current Treatment Update			Progress In Treatment		
Medication Management Information			Demographic Information		
Participation In Treatment			Cooperation with Program Rules		
Previous Treatment Information			Other:		

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. **If for other purpose, please specify:**
____:____________________________________

Revocation: I understand that I have a right to receive this authorization in writing, at any time, by sending written notification to the Director of Medical Records at Proactive Behavioral Services. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires in one year or on ______/_______/_______ whichever comes first.

Limitations: As your healthcare provider we are in the position of providing treatment, not legal or forensic expertise unless such relationship is spelled out in writing at the beginning of treatment. In the event PBS providers become involved legally in your case due to subpoena or other court mandates your insurance will not cover services and an hourly rate of $350 to $450 will apply based on discipline of provider and type of legal involvement (i.e.; deposition, testimony).SEE CONSENT FORM FOR DETAILS.

Conditions: I further understand that Proactive Behavioral Services will not place conditions on my treatment whether I give authorization for the requested disclosure.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains of as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

______________________________ ________ ____ _________
Signature of Patient **Date** **Signature of Parent/Legal Guardian/Pers. Representative** **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual:

____

______ Check here if patient refuses to sign.

____ ____________________________________

Signature of Witness Attesting to Identify & Authority **Date**