# Jean A. Leahy, Psy.D.

***Licensed Clinical Psychologist***

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize Jean A. Leahy, Psy.D. to discuss my treatment with: _____

_____

_____

For the purpose of evaluation and/or treatment planning and coordination. I understand that this consultation is confidential and will be treated as part of my counseling record by Dr. Leahy. I also give permission to the above listed provider, or institutional representatives, permission to consult with Dr. Leahy about my treatment.

Consultation will include discussion and/or release of the following documents:

- ☐ Psychotherapy assessment and treatment
- ☐ Psychotherapy appointment and billing records
- ☐ Academic records and reports
- ☐ Medical test results, diagnosis, medication & treatment, recommendations, prognosis
- ☐ Medical reports and/or records
- ☐ Court records and reports
- ☐ Other:_____

I understand that I have the right to review and copy any documents exchanged. I understand that I may revoke this consent at any time by sending written notification to Dr. Leahy's office via the U.S. Mail or private courier. Although consultation will not occur after Dr. Leahy has received my written revocation, I understand my revocation will not be effective insofar that Dr. Leahy has acted 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 Dr. Leahy generally may not condition psychological service upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

This consent is valid until _____

Refusal to consent to this release of information may have the following consequences (or indicate “none”):

_____

_____

The statutes that govern this Authorization include but are not limited to: Mental Health and Development Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/8 2001 (inspection and copying of hospital records), any relevant confidentiality code of any state, and the Employee Personnel Records Act 820 ILCS 4080.01

Dr. Leahy has explained this release and answered my questions.

| | |
|---|---|
| _____ | _____ |
| Patient’s Signature Date | Guardian’s Signature Date |
| _____ | _____ |
| Age / Date of Birth | Age / Date of Birth |
| _____ | _____ |
| Jean A. Leahy, Psy.D/Illinois License #071.004900 Date | Relationship |

**Notice to Receiving Agency/Facility/Person**: Under the provision of the Illinois Mental Health and Development Disabilities Confidentiality Act (740 ILCS 110/1et.seq.) you may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.

Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without specific authorizations for such disclosure.