Ramos & Associates
500 W. Central Rd, Suite 200
Mount Prospect IL, 60056
English: 708-789-5669 / Español: 708-890-8863

Consent to Disclose/Obtain Information

I _____, authorize Ramos & Associates Behavioral Health Clinic to [ ] disclose [ ] obtain [ ] disclose and obtain

Types of Information:

- ☐ Medical (specify): _____
- ☐ Education (specify): _____
- ☐ Financial (specify): _____
- ☐ Mental Health (specify): _____
- ☐ Social History (specify): _____
- ☐ Other (specify): _____

Concerning the care of the below named person from DATE (or range of dates): _____ to _____

About _____ SSN: _____-_____-_____ DOB: ____/____/_____

For purposes of: [ ] personal use [ ] continuity of care [ ] placement transfer [ ] financial [ ] attorney [ ] state law/court [ ] death [ ] other: _____

Information may be disclosed/obtained by: mail, in-person, phone, e-mail, or fax.
Restrictions, if any: _____

Release/Disclose Information To:	**Obtain Information From:**
Name:	Name:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Phone:	Phone:
E-mail:	E-mail:

Notice of privacy rights:
I understand that I have rights under the federal Health Insurance Portability and Accountability Act ("HIPAA") and related Illinois law that protect the privacy of my health information. I have the right to inspect and copy the protected health information that is disclosed.

I understand that I can revoke, or take back, my consent to release of this information at any time. This revocation must be in writing and must be sent to the facility's records department. I understand that if I revoke this consent, it will not have an effect on information used or disclosed prior to my action to revoke,

I understand that I have a right to refuse to sign this release form. The refusal to sign this form will result in the following consequences: **the information will not be disclosed**. I understand that my refusal to sign this form will not affect my ability to obtain services or my eligibility to receive benefits.

I understand that my records to be disclosed will contain sensitive information including, in some instances, mental health assessments, diagnoses, treatment plans, developmental disabilities, alcohol or substance abuse, or HIV/AIDs, unless specifically checked for exclusion: [ ] Mental Health [ ] Developmental Disabilities [ ] Alcohol/Substance Abuse[1] [ ] HIV/AIDs.

I understand this consent will expire on (not to exceed 180 days): _____, 20_____

_____	_____	___/____/_____
Signature of individual (age 12 or older)	Print name	Date
_____	_____	___/____/_____
Signature of parent or guardian	Print name	Date
_____	_____	___/____/_____
Signature of Ramos & Associates Staff Obtaining Consent	Staff – Print Name	Date

[1] Federal privacy law states that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient of this information. However, the Confidentiality of Alcohol and Drug Abuse Patient Records federal regulations mandate that drug or alcohol treatment information shall not be subject to further disclosure unless it is expressly authorized by written consent of the person to whom it pertains.