JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

RELEASE OF INFORMATION

Patient Name _____ Date of Birth: _____

I, the above-named patient, authorize John R Day & Associates, Ltd to *obtain from* or *release to*:

Name: _____ Phone #: _____

Check one or more of the following:

1) Discharge summary of hospitalization (s): ☐ Date of Admission (s): _____
2) Summary of outpatient psychotherapy treatment: ☐
3) School records, including IEP if applicable: ☐
4) Reports of psychological testing results: ☐
5) Summary or copies of relevant medical information: ☐
6) Summary or copies of relevant legal information: ☐
7) Other information (list here): _____

I understand that the information above is deemed necessary for my treatment. I understand that I may revoke this consent at any time in writing. This Release is effective for one year from the signature date. Please check the box(es) below to indicate your preference. If no boxes are checked, you consent for us to choose the best method for releasing your records in accordance with privacy standards.

☐ I consent for this office to ***email*** my records to the above person or entity identified above.

☐ I consent for this office to ***Fax*** my records to the above person or entity identified above.

☐ I do not consent for this office to email or Fax my records, but to send them by mail instead. Printing and handling costs may apply depending on the volume of records to be sent.

_____ _____

Patients (12 and older)/Guardian Signature **Date**

_____ _____

Witness Signature **Date**

Notice to Recipient of Information

This information has been disclosed to you from records whose confidentiality may be protected by federal and/or state law. If the records are so to protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless 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. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3716 W Brighton Ave, Peoria, IL 61615 * 309-692-7755 * Fax: 309-692-2262 * Email: home@christianpsychological.org