MARK D. PARISI, PSY.D. & ASSOCIATES, P.C.

Serving the Behavioral Healthcare Needs of Metro Chicago Since 2000

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Full Name:
_____

Patient of Doctor: ***Mark D. Parisi, Psy.D. & Associates, P.C.***

Date of Birth: _____ / _____ / _____ SSN: _____

I hereby authorize the release of information or the request of records.

To Release to / Obtain From:
_____

Address:
_____

Information to be Released / Obtained:

( ) Behavioral Healthcare Evaluations, Reports, or Treatment Notes and Summaries
( ) Billing Records
( ) Academic or Educational Records
( ) Results of Psychological / Neuropsychological Testing
( ) Other Records: _____

Purpose of this authorization:

( ) Facilitate evaluation or treatment
( ) Provide information for insurance purposes
( ) Provide information for a legal matter

It is understood that the duration of this consent will not be longer than would be necessary and reasonable to carry out the purposes for which it is given. This consent is subject to revocation in writing at any time by me or my legal guardian. However, actions already taken as specifically allowed by this form cannot be canceled by ending your consent. The terms of this consent form will end one (1) year from the signed date below with no further action on my part.

I acknowledge that I have read and fully understand this authorization as it applies to me. By my signature below, I authorize execution of the terms of this document.

_____ _____
(Signature of Client / Legal Guardian) (Today's Date)

_____
(Printed Name)

_____ _____
(Witness's Signature) (Date Witnessed)

800 E. Northwest Highway, Suite 106, Mount Prospect, Illinois 60056
Tel. (847) 909-9858 / Fax. (847) 299-4952