

Philip Burke, PhD

Licensed Clinical Psychologist

West County Medical Center
19 East Shawnee Drive
Murphysboro, IL 62966
(618) 684-8700

Request/Authorization to Release Confidential Records and Information

I hereby authorize the office of Philip Burke, PhD, (identified above) to release / obtain / exchange information from records about _____ born on _____ and whose SSN is _____ to / from / with the following person, office, or agency:

This release is for the following purpose(s):

- Further mental health evaluation, treatment, or care
- Treatment planning
- Rehabilitation program development or services
- Research
- Other: _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an x in the boxes below. Page numbers are indicated when appropriate.

- Intake and discharge summaries ____
- Medical history and evaluation(s) ____
- Mental health evaluations ____
- Developmental and, or social history ____
- Educational records ____
- Progress notes ____
- Treatment or closing summary ____
- Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above

_____ Signature of client	_____ Printed name	_____ Date
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_____ Signature of parent/guardian/ representative	_____ Printed name	_____ Relationship	_____ Date
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I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ Signature of witness	_____ Printed name	_____ Date
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- Copy for patient or parent/guardian
- Copy for source of records
- Copy for recipient of records