Dr. Swati Varma, LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete this form if you would like me to coordinate care with other treatment providers, or release information to third parties for other purposes. Please let me know about any questions.

Name of Patient: _____ Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information from Dr. Swati Varma to/from the person/facility/entity named below:

FROM:		**TO/FROM:**	
Name:	Swati Varma, Psy.D	Name:	_____
Address:	1010 Jorie Blvd, Suite 112 Oak Brook, IL 60523	Address:	_____ _____ _____
Telephone:	312. 380. 9532	Telephone:	_____
		Fax:	_____

The type of records to be disclosed are as follows (check all that apply):

☐ Records for psychological, psychiatric, emotional illness, or drug/alcohol use.
☐ Psychological assessment formal and informal
☐ Treatment plans
☐ Initial treatment reports

☐ Academic/Educational records
☐ Professional Consultation related to treatment and progress

□ Therapy or progress notes
□ Other (please specify):

_____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Swati Varma.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. In accordance with the Mental Health Code – No person or agency to whom any information is disclosed may redisclose such information unless the person who consented to the disclosure specifically consents to such redisclosure. I understand that I have the right to inspect and copy the information that is to be disclosed.

This Authorization expires on: _____ / _____ / _____. If I fail to specify an expiration date, this authorization will expire 12 months from date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information.

_____ _____
Witness Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian Date

This Authorization must be signed by the parent or guardian if patient is less than 12. In keeping with the Mental Health & Services Disability Confidentiality Act, if the patient is a minor and recipient is 12 years of age or older, then this authorization must be signed by the patient. If the patient is mentally incompetent and over the age of 18, this Authorization must be signed by the appointed legal representative of the patient.