Kathryn Doheny, PsyD

Licensed Clinical Psychologist

312.409.0899 | kathryn@doheny.com
307 N. Michigan Ave Suite 802, Chicago, IL 60601

RELEASE OF INFORMATION

I request and authorize the health care professional, agency, hospital or medical center listed below to release the information specified to:

Kathryn M. Doheny Psy.D.
307 N. Michigan Ave., Suite 802
Chicago, IL 60601

Name, address, phone number and fax number of organization or individual who is to release information

_____

_____

Information or communication requested: _____

_____

Purpose of release of information ("at request of the individual" is sufficient) _____

_____

The statutes that govern this authorization include but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/7 2001 (inspection and copying of hospital records and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01).

I understand that I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing ant any time by sending such a written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent that my provider has taken action reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above; the following are the consequences (or indicate "none")

_____

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may have a copy of this form at any time that I choose to request it. The authorization will automatically expire in one year from the date of the signature.

Full printed name of Patient

_____

Signature

_____

Date

_____