DR. KARIN M. MADSEN, PSY.D

RELEASE OF INFORMATION

I request and authorize the health care professional listed below to release the information specified to:
Karin M Madsen, Psy. D.
2625 Butterfield Road, Suite 138S
Oak Brook, IL 60523

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

_____

_____

Information or communication requested: _____

I also authorize Dr. Madsen to provide written and/or verbal information regarding my mental health treatment to the organization or individual above, IF I am currently in treatment with that organization or individual.

Purpose of release of information: at the request of the individual
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, at any time by sending such 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 in 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 therapist 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. Refusal to sign this form will result in the following consequences: information will not be disclosed/obtained.

It is my full understanding that the records and communications disclosed WILL include sensitive information such as evaluation, treatment for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDS unless specifically checked below for exclusion:
❑ Alcohol/Substance Abuse ❑ HIV\AIDS ❑ Mental health ❑ Developmental disabilities ❑ Other: _____

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. I also understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire:
❑ one year from this date
❑ upon my termination from treatment by this agency or by the person specified above
❑ under these circumstances:_____.

_____ _____ _____
Full Printed Name of Patient or Guardian Signature Date

_____ _____
Address Date of Birth

_____ _____
Signature of witness Date