
Luxury Psychiatry Clinic | WEST LOOP
213 N Morgan St #1D, Chicago, IL 60607
Ph: 312-888-2986 Fax:773-912-6727

Luxury Psychiatry Clinic | WINTER GARDEN
15835 Shaddock Dr #130, Winter Garden, FL 34787
Ph:407-603-0925 Fax:773-912-6727

AUTHORIZATION TO DISCLOSE PRIVILEGED MEDICAL INFORMATION OR REVIEW OF MEDICAL RECORDS

Patient Name: _____ _____ _____
Last Name First Name Middle initial

**Date of Birth:** ____/____/____ **Social Security Number:** _____ **Telephone: (____)- ____- _____**

Description of information that may be disclosed: Date(s) of Treatment:
___INPATIENT
___ OUTPATIENT
___EMERGENCY ROOM
___ CLINIC
___ OUTPATIENT SURGERY
___ OUTPATIENT RADIOLOGY (X-RAY)
___ OUTPATIENT LABORATORY
___ OTHER _____

I hereby authorize Luxury Psychiatry to: ☐ DISCLOSE TO: ☐ OBTAIN FROM:

Person/Facility _____

Address _____

City, State, Zip _____

I am authorizing Luxury Psychiatry to release sensitive information as indicated

☐ AIDS / HIV ☐ Behavioural Health ☐ Child Abuse
☐ Sexual assault ☐ Drug / Alcohol abuse ☐ Developmental disabilities

This information will be used for the following purposes:
☐ Continuing Care ☐Personal ☐Legal ☐ Other _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligible for benefits. I understand that I may revoke this authorization at any time by notifying the HIM department in writing. However, the revocation will not be valid if (a) Action has been taken in reliance on this authorization, or (b) if the authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.
This authorization will expire: _____
(Date, Event or Condition upon which counselor expires)

_____
Signature of Patient or Legally Authorized Patient Representative Date of signature

_____
Relationship to Patient

_____
Signature of Witness Date of signature