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CONSENT FOR RELEASE OF PATIENT INFORMATION

Name:_____ DOB:_____

Address:_____

I hereby authorize Meg O. Lukan M.S.,L.C.P.C.,LLC to: release and/or obtain specified information in my medical patient/educational record for the purpose of continued care.
Individual/Facility/Organization:_____
Address:_____
Phone Number:_____
Other:_____
Information to be used or disclosed include the available items checked below:
____Hospitalization ____Consultation/Report ___Discharge Summary
____Psychological Testing ___Initial Evaluation ___History & Physical
____Treatment Notes ___ Other

I understand that my medical records and/or information in my connection with the hospitalization/treatment date(s) used for medical care may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency (AIDS)HIV test results which are privileged and confidential and may be disclosed only online authorization, except as required by law.

I understand that this consent is revocable at any time prior to the release of this information. This authorization will expire one year from the date of my signature, unless I revoke it.

I agree to release and hold harmless Meg O. Lukan M.S.,L.C.P.C.,LLC directors, employees, or contractors from any and all liability, damages, claims, or suits, including reasonable attorney's fees, in connection with the disclosure of the records/information as authorized herein.
****** the Illinois medical record file, section 735 ILCS5/8- allowed is $0.99 per page for the first 25 pages, $0.65 four pages 26 through 50, and $0.33 for pages in excess of 50 pages.

Patient Signature:_____

Date:_____