Authorization to Disclose/Obtain Information – Child Form

I (We), (*)_____, the parent or legal guardian of (Patient Name:

(*)_____ Date of Birth: (*)_____, hereby authorize:

John A. Bartok, Ph.D.
899 Skokie Blvd., Suite 424,
Northbrook IL 60062 (847 714-9492)

and all staff members to use, release, exchange, and communicate mental health and medical information and records obtained during the course of assessment or treatment with:

Name (*)_____

Address, City, State (*)_____

Phone (*)_____Email:_____

1. The purpose of the use or disclosure is to obtain information for assessment or treatment, or to submit to insurance or other third party for reimbursement.

2. The information to be used or disclosed by John A. Bartok, Ph.D., and other employees includes any and all social, psychological, psychiatric, medical, academic, educational and behavioral information about the past and present mental health status and treatment of the above named child. I understand that this authorization extends to all of any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results, or diagnoses. Restrictions (if any):_____

This authorization is limited to only that information requested above to be disclosed to John A. Bartok, Ph.D. I/we hereby release John A. Bartok, Ph.D., from all legal responsibilities or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this authorization.

3. This consent is valid until **(*)**_____(usually 1 year from date signed)

I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party.

I/we understand that I/we may refuse to sign this authorization, resulting in the records not being disclosed.

I/we have the right to stop the use or release of this information at any time if I do so in writing to John A. Bartok, Ph.D., although I/we understand that I/we cannot do anything about information already used or disclosed pursuant to this authorization.

I/we understand that I/we can request a copy of this completed form, and that I/we understand that I/we have the right to inspect and copy the information to be disclosed and to challenge the accuracy of information contained in the subject file.

I/we intend that fax, copies, or electronic versions of this document shall carry the same force and effect as the original.

If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient.

Parent Signature: (*)_____ Date: (*)_____

Child Signature (12 and older): (*)_____ Date: (*)_____

Witness: _____ Date: _____