8745 W. Higgins Rd, Suite 110 • Chicago, IL 60631
Telephone: (312) 388-4273 • Fax: (312) 268-5044
www.gosoinc.com

AUTHORIZATION FOR RELEASE OF INFORMATION BETWEEN TWO PARTIES

Patient Name_____DOB_____
Address_____
Phone_____

I authorize the release of information and communication between the following parties:

Adriana Gonzalez Sandrolini or Mayra Soto-Gonzalez	_____
(Name)	(Name)
8745 W. Higgins Rd, Suite 110, Chicago, IL. 60631	_____
(Facility/address)	(Facility/Address)
(312) 388-4273 (312) 268-5044	_____
(Telephone) (Fax)	(Telephone) (Fax)

The purpose of this communication and release of information is _____

The following information may be released:

☐ Psychiatric history	☐ Lab reports	☐ Legal information
☐ Alcohol/Chemical	☐ HIV	☐ Family history
☐ History and physical health	☐ Neuropsychological testing	☐ Other_____
☐ Agency/clinic records	☐ School/Educational history	

Approximate dates of treatment _____

I understand that the refusal to consent to the release of the above mentioned information will prevent disclosure of the information. The consequences of refusal to consent may include incomplete diagnostic evaluation, recommendations or treatment. Additional consequences of refusal to consent may be _____

_____	_____	_____
(Signature of patient or authorized legal guardian))representative)	(Date)	(Relationship, if authorized)
_____	_____	_____
(Signature of patient or authorized legal guardian) representative)	(Date)	(Relationship, if authorized)
_____	_____	
(Witness)	(Date)	

NOTICE TO PATIENT

I understand that this consent is valid for 365 days from the date of signature, or until calendar date _____/_____/_____. I understand that I may revoke this consent at any time by giving written notice to the parties involved in the disclosure. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand that I have the right to review and obtain the information to be disclosed.

NOTICE TO RECIPIENT OF INFORMATION

Information has been disclosed to you from records whose confidentiality is protected by Federal or Illinois laws and regulations. Such laws and regulations prohibit you from making any further disclosure of the information without the specific written consent of the person to whom the information pertains or as otherwise permitted by such laws and regulations. A general authorization for release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE. The Federal and Illinois laws and regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.