Gilead Behavioral Health

Helping People. Healing Communities.

132 East 79th Street Chicago, IL 60619 | Phone: 773-487-0515 | Fax: 773-487-0525

Authorization of Release of Information

I _____, Date of Birth _____hereby give my permission to the staff of the Gilead Behavioral Health Inc., 132 East 79th Street, Chicago IL. 60619 to release information involving myself and/or my (our) child (children) to:

_____
(Name /Organization)

_____
(Address, City, State and Zip Code)

_____ _____
(Phone Number) (Fax Number)

I am signing this release form to provide informed consent to release the following:

Method in which Information may be released:

Verbal: _____ Written: _____ Photocopied: _____ Faxed: _____ Other: _____

The purpose of this disclosure is to: Please specify

_____

The timeframe within which this release of information is valid is for one year from: _____

I understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance upon it.

_____ _____ _____
(Signature) (Guardian if a minor) (Date)

Witness: _____ Date: _____

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HIPAA

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