Joseph J. Novak, Psy.D.
Clinical Psychologist
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Authorization for Use or Disclosure of Mental Health and Developmental Disability Information

Client's Name: _____
Address: _____
City/State/Zip Code: _____
Birth Date: _____ Home Phone Number: _____

I, the undersigned, hereby authorize Joseph J. Novak, Psy.D. to disclose mental health and developmental disability information regarding _____
to:
Agency/Facility/Person: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
This information is needed in order to _____.
The purpose of this disclosure is as follows: _____
_____.

I understand I have the right to inspect and copy the mental health and developmental disability information that will be used or disclosed pursuant to this authorization. I further understand that if the person(s) or organization(s) authorized to make the requested use and/or disclosure may not condition treatment, payment, or eligibility for benefits, on my executing this authorization.

This authorization is valid until _____. I understand that I have the right to revoke this authorization at any time. It has been explained to me that my refusal to consent to release of information specified above prevents disclosure of such information to those named herein.

Client's Signature: _____ Date: _____
Signature of Minor (12-17 inclusive): _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
I attest to the identity of the above signature(s):
Witness: _____ Date: _____

Under the provisions of HIPAA and under the Illinois Mental Health and Developmental Disabilities Confidentiality Act authorization for the use and/or disclosure is voluntary. Individuals are not coerced into signing an authorization but provide the information freely. Once information is received by the authorized organization/facility/person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.