

Pfeiffer Treatment Center
4575 Weaver Parkway
Warrenville, IL 60555
(630) 505-0300 Fax (630) 836-0667

Authorization for Release of Information to Third Party

Patient Name

Date of Birth

If you are 18 years or older, you have the right to refuse or allow all, part or none of your protected health information to be released.

_____ I do not authorize information to be released to a family member or caregiver.

_____ I do authorize the release of all or part of my protected health information to be communicated to a family member or caregiver. I have identified the person(s) who I am authorizing to release information and the protected health information to be released:

_____ Lab Results
_____ Billing

_____ Treatment Information
_____ Other (please explain) _____

Name

Relationship to Patient

Phone Number

Name

Relationship to Patient

Phone Number

Name

Relationship to Patient

Phone Number

If this request is by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name (please print): _____

Personal Representative's Signature: _____

Relationship to Patient: _____

Authorization Expiration: This authorization will expire one (1) year from date of patient signature unless otherwise indicated. _____

Patient Signature _____ **Date** _____

Please note: This authorization is voluntary. We will not condition your treatment on giving this authorization.