Denise M. Dojka, Psy.D.
321 Franklin, Suite B
Geneva, IL 60134
(630) 247-3742

Authorization to Provide/Obtain Information Form

This form, when completed and signed by you, authorizes Dr. Dojka to release protected health information from your clinical record to the person or entity you designate, and/or to receive such information.

I authorize Dr. Denise Dojka to ___ release ___ obtain ___ release and obtain the following information about me: (Check all that apply)

___ Diagnoses/Symptoms ___ Treatment Plan ___ Treatment Progress
___ Dates of Treatment ___ Prognosis ___ Recommendations
___ Other (Be Specific): ____

This information should only be released to (name and address of person to whom the information is to be released)
Name: ____
Address: ____
Telephone or Fax: ____

I am requesting my psychologist to release this information for the following reasons: ("At the request of the individual" is sufficient if you do not wish to state a specific purpose.)

___ At the request of the individual ___ For consistency of Treatment
___ For obtaining payment ___ For treatment planning and implementation
___ Other (Be specific): ____

This authorization shall remain in effect until _____________. If no calendar date is stated, information shall only be released on the day the authorization form is received by Dr. Dojka.

The consequences for refusing consent:
___ Possible inconsistent treatment ___ Payment in full is assumed by client
___ None ___ Other:________________________

Psychological services generally may not be denied to me if I do not sign an authorization, unless the services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to revoke this authorization, in writing, at any time by written request to Dr. Dojka. However, revocation will not be effective to the extent that information has already been released based on that authorization, or that authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I have the right to inspect and copy the disclosed mental health information at ant time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure. I further understand that if information is released to a party in another state, re-disclosure of information may be allowable according to their state law.

______________________________ ________________
Signature of Patient Date

______________________________ ________________
Witness Date

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