S.T.R.I.V.E.

Authorization for Release of Information

I, _____ _____
(Name of Applicant) (Date of Birth)

hereby authorize _____
(Name of Physician, Facility or Hospital)

_____
(Street Address of Above)

_____
(City, State, and Zip Code)

to release copies of my medical records regarding my Admission and Discharge, History and Physical, Treatment Plan, Progress Notes/Orders, Social History, Psychiatric/Psychological Evaluation, or other:_____ for the dates of service from _____ to _____ for the specific purpose of determining admission to STRIVE.

I understand that my authorization shall remain effective for 6 months after date of signature and that all information will be handled confidentially, and that I may inspect and have copies of information being released. I also understand that I may revoke this authorization at any time by written and dated communication.

I have read and fully understand this release. _____
(Date)

_____ _____
(Signature of Applicant) (Signature of Witness)

_____ _____
(Signature of Guardian) (Signature of Witness)

Please send records to: Coordinator of Admissions
S.T.R.I.V.E.
415 A Street
Prophetstown, IL 61277