Release of Information (ROI) Form

Patient Information: Name of Minor Patient: _____
Date of Birth: _____

Parent/Guardian Information:
Name of Parent/Guardian: _____
Relationship to Patient: _____

Purpose of Release:
This Release of Information (ROI) form authorizes Rossini Pediatric Neuropsychology, PLLC, to disclose the minor patient's records to the school listed below for the purpose of educational planning, accommodations, and/or intervention services.

Person/Entity Authorized to Receive Information:

Name of School: _____
School Address: _____
School Contact Person (if applicable): _____
Phone Number: _____
Fax Number: _____

Information to Be Released:
The following records and information may be disclosed (check all that apply):

☐ Neuropsychological Evaluation Report
☐ Diagnostic Summary
☐ Recommendations for Educational Accommodations
☐ Treatment summary
☐ Progress notes
☐ School reports or recommendations
☐ Testing results
☐ Attendance records
☐ Entire mental health record
☐ Other (specify): _____

Specially Protected Information (Illinois Requirement)

Initial each to authorize release:
____ Substance use treatment information
____ HIV/AIDS-related info
____ Developmental disability records
____ Sexual assault info
____ Psychotherapy notes

Authorization and Acknowledgment:
I, the undersigned, hereby authorize Rossini Pediatric Neuropsychology, PLLC, to release the information specified above to the school listed. I understand that:

1. This authorization is voluntary and may be revoked at any time by providing written notice to Rossini Pediatric Neuropsychology, PLLC, except to the extent that action has already been taken based on this authorization.
2. The information disclosed may include sensitive details about the minor patient's mental health, learning, and behavioral functioning.
3. The recipient of the information may not be subject to the same confidentiality laws as Rossini Pediatric Neuropsychology, PLLC, and may re-disclose the information.
4. This authorization will expire one year from the date of signature unless otherwise specified:

   ☐ Date: _____
   ☐ Upon completion of the purpose
   ☐ One year from date signed

Signature:
By signing below, I confirm that I am the parent or legal guardian of the minor patient and have the legal authority to authorize the release of their records.

Parent/Guardian Name (Printed): _____
Parent/Guardian Signature: _____
Date: _____

Witness:
Witness Name (Printed): _____
Witness Signature: _____
Date: _____

Contact Information for Rossini Pediatric Neuropsychology, PLLC:
Rossini Pediatric Neuropsychology, PLLC
11 N. Grant Street #204, Hinsdale, IL 60521
Phone: (773) 218-4521
Email: dr.maribeth@rossini-pediatric-neuropsychology.com

Notice of Rights and Disclosures:

- I may inspect/copy my child's records
- Once released, information may not be protected by HIPAA but remains protected under Illinois law if applicable
- Signing is voluntary
- Copies/faxes are valid.

Revocation of Authorization:
I understand I may revoke this authorization as provided under 740 ILCS 110/5. To revoke this authorization, please submit a written request to the address listed above. Revocation will not affect disclosures made prior to receipt of the revocation request.