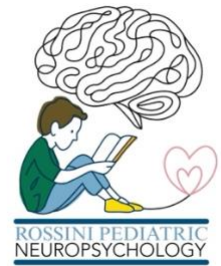


Release of Information (ROI) Form



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.