The CYPRESS Professional Group
7055 C Veterans Blvd., Burr Ridge, IL 60527
Telephone (630)325-4899 ~ Fax (630)325-4811
www.cypressprofessionalgroup.com

RELEASE OF INFORMATION

I/WE, ____ hereby authorize
(Name of Patient or Parent(s)/Guardian(s), if Patient is a Minor)

CYPRESS PROFESSIONAL GROUP

its member and/or ____ to
(Name of of Doctor or Therapist)

_____ Obtain Records _____ Release Records _____ Verbal Consent

Pertaining to ____ from/to:
(Name of Patient)

(Please give name, phone number, fax number (if available), and mailing address:

1. **My Family Member** ____
____
____

2. **My Physician, Dr.** ____
____
____

3. **My School Psychologist/Counselor** ____________________________________
____
____

4. **Other** ____
____
____

Records include: ____ **All** ____ **Diagnosis** ____ **Medication**
____ **Admission** ____ **Social History** ____ **Treatment Progress**
____ **Psychological Test and Results** ____ **School Records and Data**
____ **Others**

Covering the period from (date) ________________________ to ______________________

I/We understand that this authorization expires in 12 months and can be revoked by me/us at any time.

Signature _________________ Date ______ Witness __________________ Date _______