ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center
1 S. 376 Summit Ave., Court D, Unit 5B
Oakbrook Terrace, IL 60181
Dr. Burda: (630) 629-2700
Physicians: (630) 629-6550
FAX: (630) 629-6558

Hinsdale Professional Office Center
501 W. Ogden Ave., Suite 1
Hinsdale, IL 60521
Therapists: (630) 986-0599
Fax: (630) 986-1477

COMMUNICATION OF CONSENT

Patients Name: _____ DOB: _____

Most patients have family members and friends who occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; **OR** your adult child calls with questions about your medication; **OR** a friend calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone with whom you would allow us to communicate, please list them below. Due to privacy regulations, we cannot speak to anyone except the patient unless we have your written permission.

I give the staff of Advanced Behavioral Centers of Dupage my permission to speak with the following individuals regarding my care:

(If you prefer that we not speak with ANYONE, please write NO ONE across the lines)

NAME OF FAMILY OR FRIEND RELATIONSHIP

_____ _____

_____ _____

Restrictions to Communication: _____

_____

I request that all communications (by telephone, mail or otherwise) by the staff of Dr. Charles E. Burda and Advanced Behavioral Centers of Dupage be handled in the following manner:

*For written communications Address to: _____

_____

_____

*For oral Communications Call: _____

(Telephone Number)

May we leave message: yes ____ No _____

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize the staff of Advanced Behavioral Centers of Dupage to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____

Signature of Patient/Legal Guardian (Minors 12-17 Must sign) Date

_____ _____

_ Signature of Staff Member, Advanced Behavioral Centers of Dupage Date