Authorization for the Release of Information

I ____________________________________ hereby authorize ____________________________________
Client Name Psychotherapist Name

to release and/or exchange information with the following named facility, health care professional, or agency:

____
Name of health care facility, health care professional, agency, etc

____
Street address Suite

____
City State Zip code

____
Phone Fax

….concerning the care of:____
Client name

____
Street address Apt/Unit #

____
City State Zip code

____
Phone

…for the following purpose(s): ___ Follow-up Care ____ Evaluation/Treatment Planning

___Other (specify)____

The information to be released is: ___ Psychiatric, psychological, social only ___Complete record

___Other (specify)____

The period of time for which this consent is valid is from: _____________________ to ______________________. I understand that I have the right to revoke this consent at any time by giving written notice. However, revocation will not be effective to the extent that action has been taken to reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer maintains a legal right to consent a claim. I understand that I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such a re-disclosure.

____ ____
Client Signature Date

____ ____
Witness Signature Date