Clinical Release of Information
Confidential

I hereby authorize:

Name: _____

Address: _____

To release and/or exchange of information with:

Name: _____

Address: _____

As Initiated: _____

☐	Initial Work-up	☐	Summary of Contacts	☐	Discharge Plan
☐	Psychological Test Reports	☐	Progress Notes	☐	Psychiatric Evaluation
☐	Treatment Plan	☐	Other (specify)_____		

for the purpose of:_____

I hold harmless _____ in regard to use of information authorized for release or exchange. I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. This release expires 60 days after termination of services or at the request of the clients. I have the right to cancel this release in writing at any time; however, cancellation does not affect past action.

I understand that if I refuse to authorize the release of information the consequence(s) if any, will be:

_____

_____

Print name of client: _____

Signed: _____

Date of Birth: _____

Signature of parent or guardian: _____

Witness: _____

Date: _____

I do not authorize the release of clinical information.

Signature: _____ Date: _____

Notice to Recipient: Under Illinois and Federal confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure.

A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical chart records.

Client Name: _____

Therapist: _____