1095 Pingree Road, Suite 202
Crystal Lake, IL 60014

Authorization and Release of Mutual Exchange of Information

Client Information (Individual whose information will be released):

Client Name: _____ Date of Birth: _____

Client Address: _____

Client Phone #: _____

I, _____, hereby give consent to _____ to (select one or both) ***release*** / ***receive*** confidential, personal health information about _____ (Name) _____ (Date of Birth) with:

Person/Provider Name: _____

Person/Provider Address: _____

Person/Provider Phone #: _____

Person/Provider Fax #: _____

The following checked items may be disclosed:

- ☐ Social History
- ☐ Mental Health Treatment Records, including Assessments and Treatment Plans
- ☐ Psychiatric Evaluations
- ☐ Psychological Assessments
- ☐ Educational Plans and Records including attendance, grades, IEP/504 plans
- ☐ Substance Abuse Evaluation and Treatment
- ☐ Other (please specify): _____

The purposes for requesting/sharing this information is voluntary and can be inspected or reviewed at any time. I also understand that I make revoke this consent at any time by notifying the parties listed above in writing. Such revocation will not affect information disclose prior to revocation.

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This authorization is valid for one year and expires upon terminate of treatment. Under provisions of the Illinois Mental Health and Developmental Disabilities Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, the person or facility receiving this information may not re-disclose this information without written authorization.

_____ _____

Client's Signature Date

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

_____ _____

Witness/Therapist Signature Date

Date of Expiration: _____