The Center for Collaborative
Counseling & Psychiatry

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Authorization for Release of Information from
Center of Collaborative Counseling & Psychiatry

I hereby give permission to ***The Center of Collaborative Counseling & Psychiatry*** to:

_____ (initial) **Release** **and/or** _____ (initial) **Obtain**

The following information regarding,
_____, SS#, _____, DOB_____,
To/From_____

Disclosure of/ Request for the following specific information may be made:

___ Entire Treatment Record
___ Psychological Testing Reports
___ Psychiatric Records
___ School Records (IEP, evaluations, & reports; records of academic & behavioral functioning)
___ Treatment notes and Initial Assessments
___ Treatment plan, progress, recommendations
___ Medical Records
_____ Other (Specify):_____

The disclosure/request is for the purpose of:

___ Treatment Planning
___ Utilization review/Case management
___ Other (Specify):_____
___Coordination of care
___ Response to request

Right to revoke: I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I also understand that *Collaborative Counseling* or any of its employees cannot be held liable for any disclosures authorized by this release that occurred prior to the date of revocation.
I understand that unless revoked by written notice, this authorization for release of information is valid and binding for one year from the date signed._____ (initial)

Signature of client: _____Date: _____
Signature of Parent/Guardian:_____Date: _____
Signature of others (those 12 or over who attended sessions):
_____
Witnessed by: _____Date:_____

Notice regarding re-disclosure: The Illinois Mental Health and Developmental Disabilities Confidentiality Act, stipulates that communications and records may be re-disclosed only if the person(s) who authorized this disclosure specifically authorize such re-disclosure.
Notice of Responsibility: *Collaborative Counseling* is not responsible or liable for others use of disclosed/released information.