175 Olde Half Day Rd
Suite 140-10
Lincolnshire, IL 60069

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(Note: Please make copies of this page for each party to whom you would like us to release information. If you were referred by your doctor, please at least complete this for your doctor for coordination of care)

I, _____, hereby authorize **Kids Counseling, PC** to release regarding any and all records or information regarding_____

Name of Patient

_____

(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

_____ Mental Health Information _____ Psychology Notes _____ Drug/Alcohol Diagnosis Referral
_____ HIV/AIDS Status _____ Sexually Transmitted Diseases

TO: _____ Date of next follow up appointment if scheduled:_____

(Receiving Agency or Person)

Phone:_____ Fax: _____

Address:_____

FOR THE PURPOSE OF: (Check All That Apply)

____ Continuing Mental health/alcohol and/or drug abuse _____ Therapist transition
___Treatment or care and continuity of care _____ Housing and other arrangements and services
___Billing, payment and financial matters and arrangements _____ Other _____
___Consultation, advise and representation Regarding my condition and needs

This consent is valid until (Calendar Date): _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re-disclose it without my written authorization I also understand that if I refuse to consent to the release of information my clinician will not be able to coordinate care on my behalf.

_____ _____

(Minor Recipient, 12-17 years. Inclusive) (Signature of Adult Patient or Parent & Date)

Witness:_____ Date:_____

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Act, HIPPA, and applicable Federal and State Alcohol and Substance Abused Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. **A separate release is required for psychotherapy notes if not indicated on this form.**