AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client's full name: ___________________________________ Date of Birth: ______________

I hereby authorize **Personal Solutions Counseling, 20855 S. LaGrange Rd., Frankfort, IL 60423** to receive from or share with the person or organization named below, protected health information, including (initial):
__Psychiatric and Psychological information ___Alcohol and Substance Abuse information, ___School and Educational information, ___ Psychotherapy notes, ___ Mental Health Evaluations.

Person/Organization: ____

Address: ____

Phone: ___________________ Fax: ___________________ Email: ___________________

Initial each manner of delivery of information that you authorize: ___Mail ___Fax ___Phone ___Email

Purpose for exchanging the information: __Coordination of Care __Treatment Planning __Other: ____
____

Exchanges will include the following information:
__Assessment __Treatment Plan __Progress Notes __Referrals __Face Sheet __Dates of Service
__Type of Service __Clinical Summary __Diagnosis ___Psychosocial History

Re-release of other records from other providers, specify: ______________________________________
____
This release authorizes release of records from and to: ____

This Release will expire on: ___________________
(this release will expire in on same day as signed by the Client if no specific date is provided).

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the contact person at PSC except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. If I refuse to release information, it may negatively impact my quality of care in that providers will not be able to coordinate care between each other which may limit my recovery. RE-DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this Authorization may not be re-disclosed by the recipient to others without the written consent of this client. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding diagnosis or treatment for Mental illness, HIV or drug/alcohol abuse.

_____________________________________ ___________________
Signature of Client Date
(children age 12 and older must sign)

_____________________________________ ___________________
Signature of Parent/Legal Guardian/Representative Date
for children under the age of 12.

_____________________________________ ___________________
Witness (please have a witness sign here and print Date
their name.

Record of Disclosures of PHI:

Date of Release	Information released