Release of Information

900 Pyott Road, Suite 102
Crystal Lake, IL 60014
815.444.9076
815.444.9079 (fax)

Name_____Date of Birth_____
Address_____City_____State__Zip___
I hereby authorize_____
(person/facility) (address) (phone)
To release and exchange with _____at
The Art of Living Counseling Center 900 Pyott Road, Suite 102 Crystal Lake,IL 60014 815.444.9076
The following information from my records: (please initial all lines that apply)

___Psychological Evaluation
___Chemical Dependency Eval.
___Social Assessment
___Psychiatric Evaluation
___Neuropsychiatric Evaluation
___Vocational Assessment
___Medical/Physical History
___Lab Reports
___Educational Reports
___Progress Notes
___Discharge Summary
___Other_____

while I was a client/patient from _____to_____
The purpose of this disclosure is to facilitate continuity of care and treatment planning and/or the following_____
_____

This authorization expires on __/__/__ and is limited to only the information that I specifically requested to be sent to the facility or person named herein. The information released is not to be further disclosed or used for any other purpose than that stated in this authorization. It is understood that I have the right to revoke, in writing, and at any time, the consent contained herein. Any such revocation shall have no effect on disclosures made prior thereto. I understand that my refusal to consent to the release of information specified above will prevent disclosure of such information to the facility or person named herein.

Date:__/__/__ _____
(Client)
Date:__/__/__ _____
(Parent/Guardian)
Date:__/__/__ _____
(Witness)

Signatures require: Adult client (18 and over) and witness; Parent of Guardian and child plus witness if child is age 12-17; Parent and witness if child is under the age of 12 or client is adjudicated incompetent.