LONG GROVE CENTER FOR
Emotional Health

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____ D.O.B_______________, do hereby authorize

(Recipient of mental health services) (Date of Birth)

_____________________________________ to release AND exchange information from the clinical record regarding my protected health information to:

____

(Write name of person, health care provider, facility, or etc.)

(Address)____

(Phone) ___________________________________ (Fax)__________________________________

For the purposes of (Please check all that apply)

Treatment and Follow-up: __________________ Psychological Evaluation: ___________________

Coordination of Care: _____________________ Other (specified): __________________________

Information to be released and exchanged includes the following: (Please check all that apply for VERBAL and WRITTEN Release and Exchange)

(1)VERBAL RELEASE AND EXCHANGE

Social _____ Medical _____ Psychological _____

(2) WRITTEN RELEASE AND EXCHANGE

Social ______ Medical ______ Psychological _______

Valid from _____________________ to _____________________________

(Today's date) (Usually one year later)

I understand that I have the right to rescind this authorization at any time by sending WRITTEN notice to Long Grove Center for Emotional Health at 4180 RFD, Suite 10 Long Grove, IL 60047. I understand that a withdrawal of this release is not valid to the extent that named therapist has acted in confidence on such authorization.

Signature: ____ Date: _________________

(12 YEARS OR OLDER)

Parent/Guardian: ____ Date: _________________

Witness: ____ Date: _________________