



Release Valid: _____ (today's date) **to:** _____ (end date required)

I hereby authorize:

Name: _____

Address: _____

To release and/or exchange information with:

Name: _____

Address: _____

As initialed:

_____ Initial Assessment _____ Progress Notes _____ Psychological Test Reports

_____ Other (specify) _____

For the purpose of: _____

I hold harmless Lake Cook Behavioral Health in regard to use of information authorized for release or exchange. I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I have the right to cancel this release at any time, however, cancellation does not affect past action.

I understand that if I refuse to authorize the release of information the consequence(s) if any, will be:

Client Name (PRINTED): _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Signature of parent or guardian(if client is less than 18 y/o): _____

Witness Signature (required): _____

Notice to recipient: Under Illinois and Federal confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure. A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical chart records.