RELEASE OF INFORMATION

Date:

Client Name: Date-of-Birth:

FILE EXCHANGE WITH THE FOLLOWING BUSINESS OR ENTITY:

Business Name: _____ Provider Name: _____

Fax Number: _____ Email address: _____

CLIENT AGREEMENT TO EXCHANGE THE FOLLOWING INFORMATION:

*Please initial each category indicating full agreement by client.

	Mental Health Evaluation
	Biopsychosocial Assessment and History
	Alcohol and Drug Evaluation
	Diagnosis and Treatment Plan
	Progress Notes
	Clinical Case Summary
	All-of-the Above
	Other: please specify:

The exchanged information will be for the purpose of collaboration of care and services for wholistic client treatment and best client clinical outcomes.

VALID MENTAL HEALTH CONSENT CHECKLIST

The release must contain ALL the following components:

___Is the person authorizing a person who is designated under Section 5 (740 ILCS 110/4) of the Confidentiality act?
___Is the person or agency to whom disclosure is to be made identified?
___Is the purpose for which disclosure is to be made identified?
___Is the specific nature of the information to be disclosed identified? G Are the check boxes checked for all types of data to be disclosed?
___Are the blank lines next to the check boxes initialed for all types of data to be disclosed?
___Does the release identify that there is a right to inspect and copy the information to be disclosed?
___Does the release provide for the consequences of a refusal to consent, if any?
___Is there a calendar date on which the consent expires, provided that if no calendar date is stated, information may be released only on the day the consent form is received by the therapist?
___Is there a right to revoke the consent at any time provided?
___Is the consent form signed by the person entitled to give consent?
___Is the signature witnessed by a person who can attest to the identity of the person?

If any above element is missing the release is fatally flawed.

This Consent is Valid through: _____

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 redisclosed it without my written authorization. I also understand that if I refuse to consent to this release of information the following may occur:

_____
Minor (12yo-17yo)

_____
Adult, Parent, Guardian

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure 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.

REVOCATION OF AUTHORIZATION

_____	_____
Patient, Parent, Guardian:	Witness
_____	_____
Authorized Agent-Power-of-Attorney	Date