6040 State Route 53, Suite C, Lisle, IL 60532
Phone 630-524-4000 Fax 630-524-2311

Authorization for Release of Confidential Health Information

I, _____ Client Date of Birth: _____
Insert Name of Patient or Parent/Guardian if a minor

authorize CORE Connection Counseling to disclose to and/or obtain from:

_____ _____
[Insert Name of Person and/or Organization] Phone/Email/Fax #

the following information for _____
(Patient's name)

Description of Information to be disclosed (please initial)

_____ Assessment/Diagnosis _____ Educational Information/Evaluations

_____ Psychological Evaluation _____ Discharge/Transfer Summary

_____ Psychiatric Evaluation _____Account information

_____ Medication Management Information _____Verbal discussion _____Email

_____ Treatment Plan or Summary _____ Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services or at the request

Of the individual ☐ For Payment of Account ☐ or other _____.

I understand that:
-the practice may not condition treatment on whether I sign this authorization.
-information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by law.
-I may revoke this authorization at any time by giving written notice to the practice of my desire to do so.
-I will not be able to revoke this authorization in cases where the provider has already relied on it to use or disclose my health information.
Absent such written revocation, this Authorization for release of Confidential Health Information will terminate

in 365 days or on _____.

_____
Signature of Patient/Client (A patient aged 12-17 is required to sign the release of information in addition to the parent/guardian). Date

_____
Signature of Parent/Guardian Date

_____
Signature of Witness Date