

Consent for Release of Information

I, _____
(Client Name)
(Date of Birth)
(SS#)

request and authorize Centennial Counseling Center to

- Exchange with
 Receive from
 Provide to

_____ (Name and Address of Agency or Person to Provide or Receive Information)

information (in written and/or oral form) regarding:

- | | |
|--|---|
| <input type="checkbox"/> Initial Evaluation and Recommendations | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Diagnosis and Assessment |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Physician Notification |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Hospital Discharge Summary |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Academic Performance |
| <input type="checkbox"/> Duration of Treatment or Program | <input type="checkbox"/> Social Skills and Behavior at School |
| <input type="checkbox"/> Summary of Treatment Participation/Progress | <input type="checkbox"/> Appointment Times/Attendance |
| <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Financial/Insurance Information |

This information is for the purpose of:

- Assisting with the client's evaluation and treatment
- Coordinating services between Centennial Counseling and agency or person named above
- Transferring information regarding previous treatment
- Planning and implementing therapy for the client and/or client family
- Determining if Centennial Counseling Center services are appropriate for the client's needs
- _____

I understand that this consent will automatically expire on _____ 20____.

The consequences of a refusal to release the information itemized above may be the inability to:

- Provide continuity and/or coordination of care
- Develop a comprehensive assessment and treatment plan
- Other _____

I authorize you to send/receive copies of these records or reports to/from Centennial Counseling Center at the address shown on this form.

I understand that my clinical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information and/or Acquired Immune Deficiency Syndrome (AIDS) and/or HIV test results and information.

I authorize the release of the information itemized above solely for the purpose itemized on this consent form. Only such information and/or records believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and copy the information to be disclosed.

I understand that I have the right to revoke this consent at any time. The revocation must be in writing and received by the person releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.

I understand that the information received cannot again be given to any other agency or person without my written consent.

I understand that I do not have to sign this authorization and Centennial Counseling Center may not condition treatment on whether I sign this authorization.

 Client Signature (Parent signs for clients under the age of 12 years old) Date

 Both client and parent/guardian signature is required if the client is between 12 and 18 years old Date

 Centennial Counseling Center Staff Signature/Witness Date



**Centennial
Counseling
Center**

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 Fax 630.377.6225

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 Building
 Sandwich, IL 60548
 815.786.8606
 Fax 815.786.1541

110 E. Countryside
 Parkway
 Yorkville, IL 60560
 630.553.1600
 Fax 630.553.7993