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:

- ❑ Initial Evaluation and Recommendations
- ❑ Treatment Summary
- ❑ Psychological Evaluation
- ❑ Social History
- ❑ Progress Notes
- ❑ Duration of Treatment or Program
- ❑ Summary of Treatment Participation/Progress
- ❑ Coordination of Care
- ❑ Medical History
- ❑ Diagnosis and Assessment
- ❑ Physician Notification
- ❑ Hospital Discharge Summary
- ❑ Academic Performance
- ❑ Social Skills and Behavior at School
- ❑ Appointment Times/Attendance
- ❑ 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

1120 E. Main St.
Cedar Crossing Building
St. Charles, IL 60174
630.377.6613
Fax 630.377.6225

207 E. Church St., Suite A
John Wentworth Business Center
Sandwich, IL 60548
815.786.8606
Fax 815.786.1541

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