Gonski Counseling Services

Authorization for Release of Information

Name of Client:

Date of Birth:

Therapist:

I understand that Illinois law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Illinois law and authorize the release of records of information, but only the extent specified below.

I authorize Gonski Counseling Services to release and/or receive the following information concerning myself or my child (Circle one or more):

Diagnostic Evaluation Results

Educational Records

Progress Notes

Treatment Plan

Treatment Summary

Discharge Reports

Drug/Substance Abuse records (if Applicable)

Any and All Records

Other _____________

The above information is only to be released to, and/or from, the following party (please complete one for each entity):

Name and/or Agency:

Address, City, State, Zip Code:

Phone:

Fax:

This information is to be used for the purpose of:

This authorization shall remain in effect until ________________ at which time it shall expire, and no further release of information shall be made under its terms. If no date is entered, the release with expire one year from the date signed.

1. **Revocation:** I/we have the right to stop the use or release of this information at any time if I do so in writing, although I/we understand that I/we cannot do anything about information already used or disclosed pursuant to this authorization.

2. **Copy Received:** I/we understand that I/we can request a copy of this completed form.

3. **Inspect and Copy:** I/we understand that I/we have the right to inspect and copy the information to be disclosed.

4. **Challenge:** I/we understand that I/we have the right to challenge the accuracy of any information contained in the subject file.

5. **Effect of Copies:** I/we intend that fax, copies or electronic versions of this document shall carry the same force and effect as the original.

6. **Alcohol/Substance Abuse Files:**

If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient.

I hereby release the parties named above from any liabilities for release of this information.

Signature of Client (age 12 or older):

Date:

Signature of Parent or guardian (if patient is under 18):

Date:

Signature of Witness:

Date:

1608 Colonial Parkway, Suite 101, Inverness, Illinois Phone (630) 667-8411