KM COUNSELING
1224 Centre West Drive
Suite 200-E
Springfield, IL 62704
Phone: 217.717.4399

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

I understand that my records are protected under HIPAA and the Illinois Department of Mental Health & Developmental Disabilities Confidentiality Act and that they cannot be disclosed without my written consent, unless otherwise provided for in the regulations and/or under state specific provisions. I understand that my records may contain information regarding my mental health, substance use or dependence, sexuality, suicidality, and may contain confidential HIV (AIDS) infectious diseases related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I authorize **KM COUNSELING / KATHARINE MARTIN** to release / exchange information with:

TO/FROM: _____(_____)_____
PROVIDER NAME PHONE#

_____,_____
STREET ADDRESS CITY, STATE, ZIP CODE

RE: _____ _____ /_____/_____
CLIENT NAME DATE OF BIRTH

The following types of information:

☐ Complete record ☐ Treatment Summary ☐ Initial Evaluation ☐ Oral Communication only
☐ Other: _____

This information will be used for the purpose of evaluation, treatment and continuity of care (or):_____
_____

Further, I understand that refusal to consent to release of information will result in records not being released. If you consent to release your records, but do not wish certain information to be released, state type of information to be *excluded*:_____

I understand that the information or records above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. I understand that this consent is revocable at any time PRIOR to the release of information. This authorization will expire ONE YEAR from the date below. I hereby release you and your personnel from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____ TYPED NAME
Signature of Client (age 12yrs & older) Date

_____ _____ _____ _____
Parent/Guardian/Legal Representative Date Witness Date