AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize _____
(Facility/Provider)

_____
(Address & Phone number)

to release and obtain _____
(State specific nature of information to be disclosed)

_____.

from the clinical record of_____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

to Julie S. Blackburn, LCPC, NCC, ATR of the Chartreuse Center, 11309 Distinctive Drive, Suite 5 Orland Park, IL 60467 for the purposes of coordination of care, facilitating counseling/consultation, and/or conducting an evaluation.

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Julie S. Blackburn, LCPC, NCC, ATR. I understand that a revocation is not valid to the extent that Julie S. Blackburn, LCPC, NCC, ATR has acted in reliance on such authorization. This authorization is valid until ____/_____/_____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences that no information will be released.
☐ Any other consequences _____

_____.

A copy of this release shall have the same force and effect as the original.

_____ _____
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

_____ _____
(Therapist or Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.