4209 W Shamrock Lane Unit C,
McHenry, IL 60050
Phone: (815) 344-9443
Fax: (815) 344-9445

Center for Therapeutic Services & Psychodiagnostics

Authorization for Release of Information

Name: _____ **Date:** _____

DOB: _____/_____/_____ **SSN#:** _____/_____/_____

I authorize Center for Therapeutic Services and Psychodiagnostics to: ☐ Release to ☐ Obtain from

Name: _____

Address: _____
Address City State Zip Code

I authorize the release of the following information **BY** Center for Therapeutic Services and Psychodiagnostics:
____ Summary of Treatment (diagnosis, number of sessions attended, progress, and recommendations)
____Psychological Testing Results (may include a written report)
____Psychotherapy Notes
____Other:_____

I authorize the release of the following information **TO** Center for Therapeutic Services and Psychodiagnostics:
____Summary of Treatment (diagnosis, number of visits, progress, and recommendations)
____ Testing Results (including toxicology) ____ Medical Records
____Psychotherapy Notes ____Legal History/Legal Information
____Academic Records ____Case History
____Other: _____

Amount of Information to be Disclosed:
☐ Information covering the previous three months ☐ information covering the most recent admission
☐ Other amount of information (specify): _____

Purpose of Disclosure: ☐ to coordinate treatment ☐ to gather assessment information for treatment planning
☐ To gather information for ongoing treatment ☐ other purposes (specify): _____

Information Requested By (include credentials): _____
Expiration Date: _____/_____/_____ (Cannot exceed one year from signature date)

I expressly consent to the release of information designated above. I understand that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness, alcohol/drug abuse, and/or Human Immunodeficiency Virus (HIV)Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis. I understand the consequences and benefits of signing this release of information and have the right to inspect information to be disclosed (when applicable). I understand that I have the right to shorten the authorization period or to revoke this authorization at any time. However, the revocation must be in writing, addressed to Center for Therapeutic Services and Psychodiagnostics. I also understand that if I choose to revoke this authorization, Center for Therapeutic Services and Psychodiagnostics may have already released the above information in reliance on my original decision. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. I understand that my refusal to sign this authorization will not condition treatment or payment of services.

_____ _____
Client or Representative Date Witness Date

_____ _____
Relationship to Client **I revoke this release**