Questions? Call 708.342.1773

Professional Counseling Services

Psychological Services for Children, Adolescents, Adults, Couples & Families

Congratulations on taking the first step on the road to change!

17732 Oak Park Ave. Tinley Park, IL 60477 Website: ProCounselingServices.com

I hereby authorize: _____

_____

_____

_____

A SEPARATE FORM IS REQUIRED FOR EACH ENTITY

To use, release, and exchange mental health and medical information and records obtained during the course of treatment of:

Patient Name: _____ Date of Birth: _____

Approximate Date(s) of Service: _____ Patient No. _____ (if available)

1. **The information is to be disclosed/exchanged with the following:**

Professional Counseling Services 17732 Oak Park Avenue Tinley Park, Illinois 60062 (708) 342-1773 Fax: (708) 342-1780	SEND RECORDS TO THE ATTENTION OF: _____ PHONE: (708) 342-1773

2. **Purpose: The purpose of the use or disclosure is for:**
   - ☐ Treatment Planning
   - ☐ At the request of the parent and/or legal guardian
   - ☐ Other: _____

3. **Persons Authorized and information to be used or disclosed:**

The information to be used or disclosed by Professional Counseling Services includes only those items checked below. I understand that this authorization extends to all of any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. The information to be used or released includes:

- ☐ Discharge Summary
- ☐ Integrated Assessments
- ☐ Psychiatric Evaluation
- ☐ Physician Orders
- ☐ Physician Progress Notes
- ☐ Therapist/Social Services Progress Notes
- ☐ Treatment Plans
- ☐ Clinical Aftercare Plan
- ☐ Laboratory Data
- ☐ Psychological Testing
- ☐ History and Physical Exam
- ☐ Consultation Reports
- ☐ Education – Clinical Progress
- ☐ Education – IEP/School Assessments
- ☐ Education – School Assignments
- ☐ Medication Records
- ☐ Verbal Communication Only – No Restrictions
- ☐ ALL INFORMATION WITHOUT RESTRICTION

This authorization is limited to only that information requested above to be disclosed to Professional Counseling Services. I/we hereby release Professional Counseling Services from all legal responsibilities or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this authorization.

RECIPIENT LAST NAME: _____

Mandated Recitals:

1. **Expiration:** I/we understand that unless I revoke the authorization earlier, this authorization will automatically **expire** on _____.

2. **Redisclosure:** I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party.

3. **Refusal to sign:** I/we understand that I/we may refuse to sign this authorization and the result would be that the records would not be disclosed.

4. **Certification:** The undersigned affirms that I am (check whichever applies):
   - ☐ The recipient, and the identification that I have provided is true and correct.
   - ☐ The recipient's authorized representative, and that the identification and proof of authority that I/we have provided are true and correct. My relationship to the patient is that of:
     - ☐ Guardian ☐ Other _____

5. **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.

6. **Copy Received:** I/we understand that I/we will receive a copy of this completed form.

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

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

9. **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.

10. **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.

_____	_____	
DATE	**PATIENT SIGNATURE**	
_____	_____	_____
DATE	**WITNESS TO PATIENT SIGNATURE**	**PRINTED NAME**
_____	_____	_____
DATE	**PERSONAL REPRESENTATIVE SIGNATURE** (GUARDIAN OR OTHER AUTHORIZED AGENT)	**PRINTED NAME**
_____	_____	_____
DATE	**WITNESS TO PERSONAL REPRESENTATIVE SIGNATURE**	**PRINTED NAME**