Clinical Release of Information Form
Confidential

I hereby authorize the following people or agencies to release and/or exchange information:

Name: Address: Phone: Email:	Name: Address: Phone: Email:

The information that is to be released is as follows:

__ Initial work up	__ Summary of Contacts	__ Discharge Plan	__ Email and/or Phone

__ Psychological Test Report/s	__ Progress Notes	__Psychiatric Evaluation

__ Treatment Plan	__ Other: Specify:________________________________

For the purpose of: ____

I hold harmless Mindworks, Inc and Rossana Woldman, LCSW in regard to use of information authorized for release or exchange. I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. This release expires 60 days after termination of services or at the request of the clients. I have the right to cancel this release in writing at any time, however, cancellation does not affect past action.

I understand that if I refuse to authorize this release of information the consequences, if any, will be:

____

____

Print name of client: ________________________________ Signature of client:________________________________

Client date of birth: ________________________________ Today's Date: _____________________________________

Signature of parent or guardian: ________________________________ Date: ________________________________

Witness: ____ Date: ____

This release is valid until: ____

I do not authorize the release of clinical information:

Signature: ___________________________________ Date: ____

Note to Recipient: Under Illinois and Federal confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure.

A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical chart record.