The Center for Authentic Living
120 Main St. Suite 200
Park Ridge, IL 60068
847- 720-4773

Authorization to Release Information in Case of Emergency

I,_____ hereby authorize, _____ , to contact my emergency contact (listed below) in the case of injury or illness that occurs during session, and I am unable to call for help. I acknowledge that the individual above will be authorized to release medical information to this individual only in the case of injury or incapacitation.

I authorize _____ to call my emergency contact and preform a wellness check-up and ask about my condition under the condition I have endorsed suicidal ideation or displayed concerning behavior in group; only under the condition, that I have endorsed the previous statement, I have not shown up for group, and I have not contacted the therapist to inform her I will be missing or have not reposed to communication attempts. I acknowledge that _____ will not reveal any information about my mental health, medical records, treatment plans, or divulge personal details to this individual, and will only inquire about my physical wellness.

If emergency service needs to be contacted due to illness, injury, or for situations as demanded by law, I authorize _____ to inform medical services of any current medical conditions and medications, if I am incapacitated or unfit to do so.

I also understand that I have a right to receive a copy.
I understand that I have the right to change who my emergency contact is, and revoke previous authorizations.
I understand that I have the right to revoke this authorization at any time.
I understand that I have the right to refuse authorization or release of information.

This Authorization shall remain valid until:_____/_____/_____

A photo copy of my signature is as valid as the original.

Client's Signature: _____

Date: _____/_____/_____

Emergency Contact Name: _____

Relationship:_____ Phone Number_____-_____-_____