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

# RELEASE OF INFORMATION

**I authorize the Center for Authentic Living to disclose, release and/or exchange information to/with the following:**

| Name of person or organization | Phone | FAX |
|---|---|---|

| Address | City | State | Zip Code |
|---|---|---|---|

**Regarding:**
Patient Name: _____ Date of Birth: _____
Approximate dates of service: _____ to _____

**Purpose:**
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services, or at the request of the individual recipient. If other purpose, please specify:
_____
_____

**Requested information to be disclosed:**
*The information to be used or disclosed by Center for Authentic Living includes only those items checked below. I understand that this authorization extends to all or 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*:
□ Psychological Evaluations and Assessments
□ Progress/Psychotherapy Notes
□ Treatment Plans
□ Verbal Communications Only
□ Other: _____

**Revocation:**
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Center for Authentic Living. I understand that my signature revoking this authorization must be witnessed. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Right to Inspect and Copy:**
I understand that I have a right to inspect and copy my mental health records at any time, and before a copy is provided to anyone in compliance with this authorization, should I so choose.

**Conditions:**
I further understand that the Center for Authentic Living will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences, if any: _____
_____

**Form of Disclosure**:
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**:
Information used or disclosed in accord with this Release of Information may no longer be protected by federal or state law and could be used or redisclosed by the receiving party once the Center for Authentic Living has lawfully provided such information. You understand that the receiving party may redisclose the information pursuant to any agreement you have with him/her.

**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.

**Right to Inspect and Copy:**
I understand that I have the right to inspect and copy any information that will be released.

**Expiration:**
This release will expire on (calendar date): _____

| | |
|---|---|
| Patient Name/Signature of patient age 12 or older | Date |
| Witness Signature | Date |
| Parent/Guardian Signature | Date |
| Witness Signature | Date |