

## Authorization for Release of Information from Centers for Family Change

I hereby give permission to **Centers for Family Change** to release \_\_\_\_\_ (initial) and/or obtain \_\_\_\_\_ (initial) the following information regarding,

\_\_\_\_\_, DOB \_\_\_\_\_,

To/From \_\_\_\_\_

Disclosure of/Request for the following specific information may be made:

- |  |  |
|--|--|
| <input type="checkbox"/> Entire treatment record   | <input type="checkbox"/> Treatment notes and initial assessments   |
| <input type="checkbox"/> Psychological testing report  | <input type="checkbox"/> Treatment plan, progress, recommendations |
| <input type="checkbox"/> Psychiatric records   | <input type="checkbox"/> Medical records                           |
| <input type="checkbox"/> School records (IEP summaries, evaluations & reports; records of academic & behavioral functioning) |  |
| <input type="checkbox"/> Other (specify): _____  |  |

The disclosure/request is for the purpose of:

- |   |   |
|---|---|
| <input type="checkbox"/> Treatment planning                 | <input type="checkbox"/> Coordination of care |
| <input type="checkbox"/> Utilization review/case management | <input type="checkbox"/> Response to request  |
| <input type="checkbox"/> Other (specify): _____             |   |

*Right to revoke:* I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I also understand that Centers for Family Change or any of its employees cannot be held liable for any disclosures authorized by this release that occurred prior to the date of revocation.

I understand that unless revoked by written notice, this authorization for release of information is valid and binding for one year from the date signed.

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of others (those 12 or over who attended sessions): \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

*Notice regarding redisclosure:* The Illinois Mental Health and Developmental Disabilities Confidentiality Act, stipulates that communications and records may be redisclosed only if the person(s) who authorized this disclosure specifically authorize such redisclosure.

*Notice of responsibility:* The Centers for Family Change is not responsible or liable for others use of disclosed/released information.

releaseofinformationformJune2011/websiterevisionsJune2011

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