CENTER FOR
EMOTIONAL WELLNESS
of the Northwest Suburbs

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ D.O.B_____, do hereby authorize
(Recipient of mental health services) (Date of Birth)

_____ to release AND exchange information from the clinical record regarding my protected health information to:

_____

(Write name of person, health care provider, facility, or etc.)

(Address)_____

(Phone) _____ (Fax)_____

For the purposes of (Please check all that apply)

Treatment and Follow-up: _____ Psychological Evaluation: _____

Coordination of Care: _____ Other (specified): _____

Information to be released and exchanged includes the following: (Please check all that apply for VERBAL and WRITTEN Release and Exchange)

(1)VERBAL RELEASE AND EXCHANGE

Social _____ Medical _____ Psychological _____

(2) WRITTEN RELEASE AND EXCHANGE

Social _____ Medical _____ Psychological _____

Valid from _____ to _____
(Today's date) (Usually one year later)

I understand that I have the right to rescind this authorization at any time by sending WRITTEN notice to The Center for Emotional Wellness at 800 McHenry Ave, Crystal Lake, IL, 60014.
I understand that a withdrawal of this release is not valid to the extent that named therapist has acted in confidence on such authorization.

Signature: _____ Date: _____
(12 YEARS OR OLDER)

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____