



**AUTHORIZATION FOR RELEASE OF MENTAL HEALTH,  
ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION**

I \_\_\_\_\_, hereby authorize \_\_\_\_\_ to  
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

exchange\release any and all records or information regarding \_\_\_\_\_  
(Client's name)

\_\_\_\_\_  
(State specific nature of information to be disclosed.)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

- \_\_\_ Mental Health Information       \_\_\_ Medical records and information       \_\_\_ Psychotherapy Notes

This information should only be **released to and/or exchanged with:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

For the purpose of: (please check all that apply)

- Continuing (health and mental health) treatment or care and continuity of care       Therapist transition  
 Housing and other arrangements and services       Billing, payment and financial matters and arrangements  
 Consultation, advise and representation regarding my condition and needs       Other \_\_\_\_\_

This authorization shall remain in effect until: \_\_\_\_\_ (month/day/year)

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur \_\_\_\_\_

\_\_\_\_\_  
(Minor recipient, 12-17 yrs. Inclusive)

\_\_\_\_\_  
(Signature of adult patient or guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

**NOTICE TO PATIENT AND RECEIVING AGENCY**

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

**REVOCATION OF AUTHORIZATION**

The undersigned hereby revokes the above authorization for disclosure.

\_\_\_\_\_  
(Client, Guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Authorized agent - Power of attorney attached)

\_\_\_\_\_  
(Date)