

Cardia Counseling Center, Inc.

24W146 St. Charles Road, Wheaton, IL 60188
630-272-2313

Authorization to Release Information

This form when completed and signed by you, authorizes me to release protected information from your Clinical Record to the person designated below.

I, _____, authorize _____ / Cardia Counseling Center to disclose information to and/or obtain information from:

Person's Name, Organization, Address, Phone

the following information:

- Assessment, Diagnosis, Psychosocial Evaluation, Treatment Plan or Summary, Progress Reports, Presence/Participation in Treatment, Demographic Information, Psychological Evaluation, Psychiatric Evaluation, Medication Management Information, Chemical Dependency Evaluation, Educational Information, Discharge/Transfer Summary, Continuing Care Plan, Nursing/Medical Information, Other

Purpose

The purpose of this disclosure of information is usually to improve assessment and treatment planning, share information relevant to treatment and when appropriate, to coordinate treatment services and/or provide continuity of care. Please specify if other purpose: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Cardia Counseling Center 24w146 Saint Charles Road, Wheaton, IL 60188. 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 or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Expiration

Unless sooner revoked, this consent expires on the following date: _____

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

State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et.seq).

I understand that I have the right to inspect and copy the information to be disclosed. I also have a right to a copy of this authorization for my records.

Signature of Client(s) Date
Signature of Parent, Guardian or Personal Representative Date
If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).
Signature of Staff Witness (Attesting to Identity & Authority) Date