Thriving Lives Counseling, LLC
9641 West 153rd Street, Suite 48
Orland Park, IL 60462
www.thrivinglivescounseling.com
Tel: (708) 963-0333 Fax: (708) 665-1829

CLIENT CONSENT TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

Home Address: _____

_____

Home Phone: _____

I hereby authorize _____ to use or disclose, in verbal and/or written form, the specific information described below, only for the purpose and parties also described below.

(Name) _____

(Address) _____

(Phone #) _____ (Fax #) _____

(Check one) One-way release: _____ Two-way release: _____

Check only the specific information to be used or disclosed:

_____Treatment Summary
_____ Psychological testing/evaluation
_____Psychological History
_____Psychiatric History/Medications
_____Substance Use/Abuse History
_____Discharge Summary
_____Other (specify) _____
_____Social History
_____School Functioning
_____Educational Testing/Evaluations
_____Medical Information
_____Child Advocacy

The information is being requested for the following purpose(s):

_____Treatment planning
_____Follow-up care
_____Other (specify) _____
_____Coordination of ancillary services
_____Evaluation

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This authorization shall remain in effect from the date signed below until _____(date)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation to the attention of Thriving Lives Counseling, LLC.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).
- I hereby release *Thriving Lives Counseling, LLC* from any and all legal responsibility or liability or for any consequences of either: 1) having non-stipulated information maintained in confidence or privacy; or 2) disclosing stipulated information.

_____ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Client Signature: _____ Date: _____
(Age 12 and over)

Parent/Guardian Signature: _____ Date: _____

Witness Name: _____

Witness Signature:_____ Date: _____
The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.