Counseling Offices of Lisa Collins LCSW, Jennifer Nichols LCPC and Kristin Hultgren LCPC
801 E. Main Street - St. Charles, IL 60174

Authorization for Release of Information

I authorize the Counseling Offices of Lisa Collins LCSW, Jennifer Nichols LCPC and Kristin Hultgren LCPC to _____ exchange with: _____ receive from: _____ release to:

_____
(agency/facility/person) (phone and/or fax)

_____the following:
(address of agency/facility)

	Assessment		Treatment		Other Information
	Psychiatric/Psychosocial		Psychiatric/Psychosocial		Medical History
	Psychological		Medical		Lab Results
	Educational		Substance Abuse		Discharge Summary
	Substance Abuse		Individual Education Plan		Legal (specify below)

If the authorization is for a hospitalization please specify dates: _____
(minimum month/year)

If legal or other, please specify: _____

About:_____ Date of Birth: / /
(Client's name)

For the purpose of _____ Assessment _____ Treatment Planning _____Coordination of Care
_____ Other: please specify _____

I understand that this information may be transmitted in the following mode which is acceptable:
_____Written _____Verbal _____ Electronic

This consent is valid until calendar date / / (not to exceed 6 months).
I understand that the above named agency/facility/person is authorized to receive or exchange this information and has a right to inspect and copy the information to be disclosed. I understand that I may revoke this consent at any time and that revocation must be in writing. I have had a full opportunity to read and consider the contents of this authorization and confirm that the contents are consistent with my consent.

_____ Date: _____
Recipient (12 and older)

_____ Date: _____
Parent/Guardian of minor or Guardian of a disabled recipient

_____ Date: _____
Witness