Polaris Counseling
800 W. 5th Avenue
Suite 205 I
Naperville, IL 60563

Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or facility: ____
Address: ____
Phone: ______________________ to release information from records about ____________________ born on __________, to **Polaris Counseling** for the following purpose(s):

☐ Further mental health evaluation, treatment, or care or services ☐ Treatment planning ☐ Research ☐ Rehabilitation program development ☐ Other: __________________

The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

☐ Intake and discharge summaries ☐ Medical history and evaluation(s)
☐ Mental health evaluations ☐ Developmental and/or social history ☐ Educational records
☐ Progress notes, and treatment or closing summary ☐ Other: __________________

Select only one:

☐ Please forward the records to the address in the letterhead at the top of this form.
☐ Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

______________________ ______________________ __________
Signature of client Printed name
Date

______________________ ______________________ ______________ __________
Signature of parent/ guardian/representative Printed name Relationship Date

______________________ ______________________ __________
Signature of witness Printed name
Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

☐ Copy for patient or parent/guardian ☐ Copy for source of records ☐ Copy for recipient of records

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