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   ☐ Rehabilitation program development or services
☐ Treatment planning   ☐ Research   ☐ 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: _____

Please forward the records to Polaris Counseling, 800 W. 5th Avenue, Suite 205A, Naperville, IL 60563.

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/   Printed name and Relationship   Date
guardian/representative

_____   _____   _____
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