AUTHORIZATION FOR RELEASE OF INFORMATION
(GENERAL)

This release may be used for a two-way information release YES_____ NO_____

This form, when completed and signed by you, authorizes your therapist to release protected information from your clinical record to the person(s) and entities you designate.

I AUTHORIZE:

Amy Silver, L.C.S.W., LLC
801 Skokie Blvd., Ste 109
Northbrook, IL 60062
847.612.7706
amysilverlcsw@gmail.com

TO RELEASE TO

Organization:_____
Name:_____
Address:_____
City/State:_____
Zip:_____
Phone:_____
Email:_____

REGARDING:_____ BIRTH DATE:_____

HOME ADDRESS:_____

FOR THE PURPOSES OF:_____

VALID UNTIL:_____
(duration of authorization is one year unless otherwise specified above)

In signing this form, I understand the following provisions:

a) I am under no obligation to sign. I understand my therapist(s) generally may not condition therapeutic services upon my signing this Authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party.
b) Failure to sign will mean that the information will not be requested or released. One consequence for refusing to release this information includes, but is not limited to, a failure on the part of the receiving party to fully appreciate, or to be aware of client's pertinent history or current condition.
c) I have the right to revoke this authorization at any time by written request. However, my revocation will not be effective to the extent that my therapist has taken action 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.
d) I have the right to inspect and copy the mental health information disclosed at any time.
e) Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this Authorization unless the Authorization specifically authorizes such re-disclosure.
f) If this Authorization is signed by a personal representative of the client, a description of the representative's authority to act for client must be provided.

SIGNATURE:_____ SIGNATURE:_____
(Adult or Guardian for Minor) (Minor 12 to 18 Years of Age)

DATE:_____