CLIENT CONSENT TO RELEASE INFORMATION

Client Name _____
(please print full legal name)

Date of Birth ____/____/____ Social Security Number ____–____–____

I hereby authorize and request _____ of Laurie Kahn &
(Clinician / Person)

Associates, Inc. D/B/A Womencare Counseling Center to release to, obtain from, and discuss the following with:

_____
(Person / Agency)

_____
(Address, City, State, Zip)

(____) _____
(Telephone Number)

This information will be used for the purpose of evaluation and planning and is confined to the following specified information:

_____

_____

_____

_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, no person or agency to which any of this information is released may disclose the information unless redisclosure is specifically consented. I understand that I may revoke this consent at any time, but not retroactive to the prior release of information made in good faith. I understand that if I decide to revoke this authorization that such revocation must be in writing and signed, dated, and witnessed. Additionally, I understand that I have the right to inspect and copy information disclosed.

This authorization is valid until ____/____/____. If no date is specified, this
(month, date, year)
authorization is valid until one year from the date signed.

_____ _____
Date Signature of Client

_____ _____
Date Signature of Guardian
(Required if client is under 12 years of age or has been adjudicated incompetent)

_____ _____
Date Signature of Clinician

Committed to helping individuals develop healthy relationships with themselves and others.

Director
Laurie Kahn, MA, LCPC

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