

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION*

North Shore Wellness Services, Ltd.
Office & Mailing Address: 3000 Dundee Rd., Suite 411, Northbrook, IL 60062
Phone: (847) 205-0371 Fax: (847) 205-0377

Client's Name: _____ Birth Date: _____

I, _____, authorize _____,
Client's Name Therapist's Name

an Independent Practitioner / Employee (circle one) at North Shore Wellness Services, Ltd., to

[release] [request] [share] (circle all that apply) confidential medical record information

[to] [from] [with] (circle all that apply), _____
Name of Provider/Therapist/PCP Phone #

Information shall consist of: Duplicate records/ verbal consultation concerning treatment and/or education.

Specifically:

- | | | |
|---|---|---|
| <input type="checkbox"/> All Clinical Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol tests & results |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> PCP Contract Form | <input type="checkbox"/> Drug/Alcohol diagnosis, treatment, referral info |
| <input type="checkbox"/> Educational Evaluation | <input type="checkbox"/> Master Treatment Plan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Psychiatric Evaluation | |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Mental Health Info | |

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information**) may be protected by Federal Regulations. **Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Client or Legal Representative Date Witness Date

- I do not give my mental health provider permission to contact my primary care physician, therapist or other type of provider.

Signature of Client or Legal Representative Date Witness Date

*PRIVACY ACT STATEMENT

1. The authority for soliciting the information comes from 10 USC 3012
2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.
3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed.
4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy