PATHWAYS COUNSELING

1325 Remington Road, Suite C
Schaumburg, IL 60173
(630) 209-7359

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
(Client Name) (Date of birth)

I authorize _____ and

Name/Address _____

_____

_____

Phone (_____) _____

(_____) _____

To disclose the following information: _____

_____

_____

for coordination of care, evaluation and treatment.

The person or agency to whom I disclose this information may not redisclose this information to a third party without my consent. I understand that I have the right to inspect and copy the information to be disclosed and have the right to revoke this authorization, in writing, at any time (consent cannot be revoked retroactively). This authorization is valid until _____ _____.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences _____ _____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.