Kate Hinkle, PsyD
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Authorization for the Release of Confidential Information

Client Name: _____

Client Date of Birth: _____ Client Phone Number: _____

Collaborating Clinician/Agency/Person: _____

Contact Number: _____ Fax Number: _____

For the following purpose(s): ____ Evaluation/Treatment Planning/Treatment Coordination

___Other (specify): _____

The information to be released is: ___ Treatment Summary ___Complete record

___Other (specify)_____

The period of time for which this consent is valid is from (today's date): _____
to (one year from today's date): _____

I authorize Kate Hinkle, PsyD to communicate with the above named clinician, agency, or person for the purpose of coordinating treatment. I understand that I have the right to revoke this consent at any time by giving written notice. However, revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer maintains a legal right to contest a claim. I understand that I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such a re-disclosure.

_____ _____
Client Signature Date