STOPKA
PROFESSIONAL COUNSELING

# Authorization to Release Information

Individual's Name: _____ Birthdate: _____

Street Address: _____

City, State, Zip: _____

I authorize Stopka Professional Counseling to **release/receive** (circle one) protected health information as directed below:

1. **Name and address** of person or organization **to/from** (circle one) whom disclosure is to be made:
Name: _____

Street Address: _____

City, State, Zip: _____

Phone/Fax Number: _____

2. **Specific Information** to be disclosed: _____

_____

3. **Specific Purpose** of this disclosure: _____

4. **Revocation/Expiration**. This authorization can be revoked in writing at any time unless the provider has already acted upon the request.

Without expressed written revocation, this authorization expires 90 calendar days after it is signed, or upon the following specific date, event or condition: _____

5. **Conditions**: If I decline to provide authorization for disclosure, no consequences or conditions will be placed on my rights as a recipient except as specified here: _____

6: **Re-disclosure**: State and federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the recipient. All use of protected health information is governed by 42 CFR Part 2 and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

I understand that I have the right to inspect and copy the information to be disclosed. I may request a copy of this authorization for my records.

_____ _____
Signature of Individual (age 12 or older) Date

_____ _____
Signature of Parent, Guardian, or Personal Representative Date

_____ _____
Witness Signature Date