Inspire
Therapeutic Services, LLC

Authorization to Release Information

Client Name: _____ Date of Birth_____

Date authorization is initiated: _____

This is to authorize that the information below regarding the above person be disclosed between:

Inspire Therapeutic Services, LLC		Person or Facility: _____
PO BOX 584	**and**	Street: _____
North Aurora, IL 60542		City/State/Zip: _____
Phone: 630-755-5300		Phone: _____

This authorization shall remain in effect until: _____ (Fill in an expiration date or an event that relates to the purpose of the disclosure.)

_____Termination of Services _____Other (please specify) _____

If this authorization does not contain an expiration date or event, it expires 90 days from the date of my signature.

Specify information to be disclose, *please initial request*.

_____Intake Evaluation _____Diagnostic Assessment

_____Psychological Evaluations _____Clinical Summary

_____Treatment Plan _____Other: _____

Purpose of Disclosure:

_____ Personal Use _____ Attorney/Court _____ Continuation of Care _____ Financial Benefits

We do not release clinical session notes unless required by Insurance and Court Order.

I understand that my records may contain information relating to my mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel authorization at any time, except to the extent that the action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client:_____ Date:_____

Parent/Guardian Signature (client under 18) _____ Date: _____

Note: A photocopy of this authorization shall be considered in lieu of the original.