Alison McGannon, LCPC
3047 N. Lincoln Ave. Suite 400 Chicago IL 60657
773-835-3366

Consent to Release Information

Name:_____ Date of Birth:_____

I, _____ authorize ____Alison McGannon, LCPC_____.
Client Counselor

Address: 3047 N. Lincoln Ave., Suite 400 Chicago IL 60657
Phone: 773-835-3366

To exchange information with: _____ _____

Type of Information to be released:_____
Purpose:_____
NOTICE TO RECEIVING AGENCY/PERSON: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.)

I understand that:

1- This consent will expire **on the following date:_____.**
2- I have the right to inspect and copy the information to be disclosed. I will be g/iven a copy of this authorization for my records.

3- I may revoke this consent at any time by giving written notice to Alison McGannon, LCPC at that address above.

4- Failure to sign this release of information will have the following consequences:

_____
Signature of Client Date

_____
Signature of Parent, Guardian, or Personal Representative Date
(If you are signing as a personal representative, describe your authority to act for this individual – power of attorney, etc.)

_____
Signature of Witness Date