Naperville Aurora Counseling Center
Plainfield Counseling Center

4012 W. Renwick Rd, Unit 204
Plainfield, IL 60544
815-676-4688
ainfieldcounselingcenter.com

3909 75th St, Unit 101
Aurora, IL 60504

Request/Authorization to Release Confidential Records and Information

A. Identifying information about me/the client (Name/Phone/Birthdate):

_____

B. To be released to/from (Name/Phone/Address):

_____

C. I hereby authorize the source named above to release and receive, as promptly as possible, verbal and/or written records listed below marked by an X in the boxes below for psychological, psychiatric, emotional illness or drug and/or alcohol abuse:

- ❑ Psychological evaluation(s) or testing records, and behavioral observations checklists completed by any staff member or by the patient
- ❑ Psychological and/or Psychiatric evaluations, diagnoses, reports, or progress notes and summaries
- ❑ Treatment plans, service plans, recovery plans, aftercare plans
- ❑ Admission and discharge summaries
- ❑ Social histories, assessments with prognoses
- ❑ A letter containing dates of treatment(s) and a summary of progress
- ❑ Drug and alcohol information
- ❑ Billing records

For the Purpose of: ❑ Continuation of Care ❑ Insurance ❑ Legal ❑ Personal
❑ Other_____

Method of Disclosure: ❑ Verbal Exchange of Information ❑ Copy of Record

D. This request/authorization is valid during any claim or demand made by or in behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. This release pertains only to the treating clinician (signed below) and not Plainfield Counseling Center, PLLC, Naperville Aurora Counseling Center, PLLC or any of their licensees. I understand that I may void this request / authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization it will remain in force until treatment has concluded.

E. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

G. Signatures:

_____ _____

Signature of Client and Date | Signature of Guardian/Witness and Date

_____ _____

Signature of Clinician and Date | Printed name of Guardian/Witness

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law. V. 8/22/2022