Healing Center at Silver Lake Gardens
15127 S. 73rd Ave. Suite C
Orland Park, IL 60462
708-586-9303
Fax: 866-950-9427

Healing Center for Behavioral Health
1005 W. Laraway Rd., Suite 230
New Lenox, IL 60451
815-570-9303
Fax: 866-950-9427

Provider rendering treatment: Counselor: _____

OT: _____

BCBA: _____

CONSENT TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I, _____, hereby authorize the **Healing Center**
(Name of Patient or Authorized Agent)

to release to/or secure from _____
(Name of Health Care Facility, Physician, Agency etc.)

_____
(Street Address, City, State and Zip Code)

The following information in the patient record of: _____, born _____
(Patient's Name) *(Date of Birth)*

To be disclosed, the following items must specifically be checked:

☐ Account Information ☐ Treatment Summary

☐ Office Psychotherapy Notes ☐ Verbal Discussion of Case

☐ Psychological Testing Report ☐ Other (specify): _____

The purpose(s) of the authorization is (are):

☐ At the request of the individual ☐ Coordination of Mental Health Treatment

☐ Payment of Account ☐ Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Consent to Release Confidential Health Information will terminate on _____.
(Date)

Date: _____ _____
(Signature of Client)*

_____ _____
(Signature of Witness) *(Signature of Parent or Guardian)*

*Client signature is required in addition to the parent or guardian signature for clients ages 12-17.