The Plains Clinic

1400 Lincoln Highway, Suite C
St. Charles, IL 60174
Phone 630 214-1082 Fax 630 214-1083

AUTHORIZATION TO RELEASE INFORMATION

I, (**patient name or name of child if under 18 yrs.**) _____,
(hereinafter "Patient) hereby authorize (**name of clinician**) _____,
(hereinafter "Provider") to disclose mental health treatment information and records obtained of Patent, but not limited to, therapist's diagnosis of Patient, to:

_____

_____.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider at 1400 Lincoln Highway, Suite C, St. Charles, IL 60174 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

_____.

The specific uses and limitations of the types of information to be discussed are as follows:

_____

_____.

Such disclosure shall be limited to the following specific types of information:

_____

_____.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable law may protect such information.

This authorization shall remain valid until: _____.

Patient's signature: _____ Date: _____.

Parent (when applicable): _____ Date: _____.