CLIENT NAME: _____

ADDRESS: _____

CITY/ZIP: _____

BIRTHDATE: _____ DATE: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Catholic Charities Diocese of Joliet Counseling Department

16555 Weber rd Crest Hill IL 60403

(Agency/Address)

to release/exchange the following written/verbal information with _____

_____

(Agency/Address)

For the purpose of care coordination

The following information may be shared (check applicable items):

Mental health assessment and treatment	☐ Yes	☐ No	☐ N/A
Psychiatric evaluation and treatment	☐ Yes	☐ No	☐ N/A
Substance abuse assessment and treatment	☐ Yes	☐ No	☐ N/A
HIV/AIDS status	☐ Yes	☐ No	☐ N/A
Summary of treatment	☐ Yes	☐ No	☐ N/A
Discharge summary	☐ Yes	☐ No	☐ N/A
Presence and Participation in Treatment Services Only	☐ Yes	☐ No	☐ N/A

This consent is valid until _____ _____

(If no date is listed, release is valid for 1 year) Clinician Signature

I understand I may revoke this consent at any time* and I have the right to inspect and copy the information to be released. It has been explained to me that if I refuse to sign this Release of Information, the following are the consequences (specify, if any):

_____

*Any revocation of consent shall have no effect on any disclosures made prior thereto.

I understand the information obtained as a result of this release may not be redisclosed unless I specifically consent to it. Catholic Charities will not redisclose any information from outside sources without a specific signed release of information.

Client Signature _____ Date _____

Guardian/Parent/Legal Relationship _____

Witness _____ Date _____

Signatures of all clients between the ages of 12 to 18 and parent/guardian are required for disclosure information.