CONTRAST
COUNSELING

3166 N. Lincoln Ave Ste 207
Chicago, IL 60657

Authorization for Release of Protected Health Information

Legal name: _____

I, _____, hereby authorize Contrast Counseling, PLLC to

release information to/from:

Agency/Facility/Person: _____

Email address: _____

Telephone number: _____

This authorization permits the disclosure of the following information:

____ Medical history and evaluations ____ Mental health evaluations ____ Discharge summary

____ Developmental and/or social history ____ Educational records ____ Progress notes

____ Treatment plans ____ Record Abstract (All of the above options) ____ Other (please specify):

_____

These records are released for the purpose of (check all that apply):

____ Continuity of Care ____ Legal ____ At the request of the client

____ Determining eligibility for benefits or program

This authorization expires on the following date:

_____

I understand that this authorization is voluntary and that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following:

Contrast Counseling, PLLC
3166 N. Lincoln Ave Ste 207 Chicago, IL 60657
becky@contrastcounselingchicago.com

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to inspect and copy the information to be disclosed. I understand the consequences of the refusal of consent are that the information will not be disclosed and that may impact the continuity of my treatment depending on the purpose of the disclosure.

_____ _____
Signature of Client or Legally Authorized Representative Date

_____
Relationship to Client

_____ _____
Signature of Witness Date