CONTRAST
COUNSELING

3166 N. Lincoln Ave Ste 207
Chicago, IL 60657

Authorization for Reciprocal 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 exchange 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):

_____

This abstract will include sensitive information such as substance abuse and HIV/AIDS unless checked below. Only check if you **do not** want this information shared:

____ Substance Abuse ____ HIV/AIDS ____ Other: _____

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

____ Continuity of Care ____ Attorney/Client Relationship

____ Determining eligibility for benefits or program ____ At the request of the client

This authorization shall be in force and effective until the following event and/or date:

_____

I understand 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 understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. 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 receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____
Signature of Client or Legally Authorized Representative Date

_____
Relationship to Client

_____ _____
Signature of Witness Date