Request/Authorization to Release Confidential Records and Information

I hereby authorize Person or facility:

___________________________________Address:____
______________________________Phone: _________________________________ to release information from records about ____________________________________ born on _____________, to or from Eunoia Counseling for the following purpose(s):

 Further mental health evaluation, treatment, or care Rehabilitation program development or services Treatment planning Research Other:

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The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

 Intake and discharge summaries Medical history and evaluation(s)

 Mental health evaluations Developmental and/or social history Educational records

 Progress notes, and treatment or closing summary Other:

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Please forward the records to info@EunoiaCounselinNaperville.com or Eunoia Counseling, 29 S. Webster St, Ste 290, Naperville, IL 60504.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_______________________________________ _____________________________________
__________________ Signature of Client/Guardian and Printed name Date