CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

CHILD

A SEPARATE FORM IS REQUIRED FOR EACH ENTITY

AUTHORIZATION FOR RELEASE/EXCHANGE OF PATIENT INFORMATION

I hereby authorize:

Counseling and Diagnostic Center of Woodfield, Ltd.
955 N. Plum Grove Road, Suite C
Schaumburg, Illinois 60173
Telephone: (847) 884-0210
Facsimile: (847) 884-7349

to use, disclose to, release and/or exchange mental health and medical information, records, and communications obtained during the course of treatment from:

_____/_____/_____ to _____/_____/_____
[insert approximate dates of service]

regarding _____ whose date of birth is: _____/_____/_____
[Patient Name]

1. The information is to be disclosed/exchanged with the following:

_____

_____

_____

2. Description of Information to be Used or Disclosed:

The information to be used, obtained by, or disclosed by/to Counseling and Diagnostic Center of Woodfield, Ltd.(CDCW) includes only those items checked below. I understand that this Authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. This Authorization is limited to only that information indicated below to be disclosed to or by CDCW. I hereby release CDCW from any and all legal responsibility or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this Authorization. (Patient should initial each item to be disclosed).

_____ Psychological Testing
_____ Consultation Reports
_____ Medication Records
_____ Discharge Summary
_____ Presence/Participation in Therapy
_____ Physician Orders
_____ Progress/Psychotherapy Notes
_____ Clinical Aftercare Plan
_____ Drug/Alcohol History
_____ Other:

_____ Mental Status Exam
_____ Education - Clinical Progress
_____ Education – IEP/504 Plans
_____ Education – School Assignments/Assessments
_____ Psychiatric Evaluation
_____ Physician Progress Notes
_____ Treatment Plans/Treatment Summaries
_____ Laboratory Data
_____ Recommendations
_____ Verbal Communications Only

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3. Purpose of the Use or Disclosure is for:

- ☐ Continuity of Treatment
- ☐ Family Involvement
- ☐ Consultation
- ☐ Referral
- ☐ At the request of the patient and/or parent and/or legal guardian
- ☐ Other: _____

4. Expiration:
I understand that unless I revoke this Authorization earlier, this Authorization will automatically expire on: _____/_____/_____.
[Insert calendar date]

5. Redisclosure:
I understand that information used or disclosed in accord with this Authorization may no longer be protected by federal or state law and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party.

6. Refusal to Consent:
I understand that I may refuse to sign this Authorization and the result would be that the mental health records and/or communications would not be disclosed.

7. Certification:
The undersigned affirms that I am (check whichever applies):

- ☐ The client and the identification that I have provided is true and correct.
- ☐ The client's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the client is that of:
  _____ Parent _____ Guardian _____ Other: _____

8. Revocation:
I have the right to revoke this Authorization at any time if I do so in writing, although I understand that I cannot do anything about information already used or disclosed pursuant to this Release of Information.

9. Copy Received:
I understand that I will receive a copy of this completed form upon request.

10. Right to Inspect and Copy:
I understand that I have the right to inspect and copy the information to be disclosed.

11. Effect of Copies:
I intend that fax, copies, or electronic versions of this document shall carry the same force and effect as the original.

12. Alcohol/Substance Abuse Files:
If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse client.

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Date		Printed Name
	Client Signature - age 12 and older	
Date	Witness to Client Signature	Printed Name
Date	Personal Representative Signature (Parent, Guardian, or Other Authorized Agent)	Printed Name
Date	Witness to Personal Representative Signature	Printed Name