Fox Bend Counseling
Mental Health Treatment Release of Information

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I, _____ whose date of birth is _____
Authorize Fox Bend Counseling, 123 W. Washington St., Suite 321 Oswego, IL 60543, and 630-383-2077 to disclose to and / or obtain from:
The following information: (All information must be filled out or invalid)

Name of person/organization:

Address:

Phone Number/Fax Number:

Description of Information to be disclosed:

____ Assessment	____ Medication Management Information	____ Demographic Information
____Treatment Plan or Summary	____ Presence/ Participation in Treatment	____ SOAP/ Progress Notes
____Diagnosis	____ Continuing Care Plan	____ Verbal Exchange only, nothing written
____Psychosocial Evaluation	____ Progress in Treatment	____Psychiatric Evaluation
____Other	____Current Treatment Update	____ ALL

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation:
Unless sooner revoked, this will expire one year from the Signature date: Or as otherwise indicated_____

Expiration:
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Joliet Center Clinical Research. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions:
I further understand that Joliet Center Clinical Research will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Non-disclosure.

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in a certain format. We reserve the right to disclose information as permitted by this authorization in any matter that we deem to be appropriate and consistent with applicable law, but not limited to, verbally, in paper format or electronically.

Disclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPPA privacy regulations, unless a State law applies that is more strict than HIPPA and provide additional privacy protections.

Signature of the Patient _____Date_____
Signature of Personal Representative _____ Date_____
Signature of Witness_____ Date _____
Relationship to Patient If Personal Representative_____