UNION COUNTY COUNSELING SERVICES, INC.
RELEASE OF INFORMATION

I, (CLIENT'S name Age 12 or older or Parent/Guardian) ___________________________D.O.B._________________
HEREBY GIVE CONSENT TO **UNION COUNTY COUNSELING**, P.O. Box 548, Anna, IL 62906 **TO RELEASE THE FOLLOWING INFORMATION VIA:___written _______verbal _______FAX _______courier _______ other (_______________________) FROM DATE:___________________TO_________________________**

_______Psychiatric Evaluation(s) _______Medications _______Treatment Plans
_______Psychiatric Notes _______Laboratory Results _______Progress Notes
_______Discharge Summary _______Crisis Assessments _______Social History
_______Treatment Recommendations _______Rep Payee Information _______Other: medical______
_______Mental Health Assessments _______Daily Living Behavior

TO:____
Name Phone Number

____
Address Fax Number

FOR THE PURPOSE OF: _______Coordination of Services and/or Continuity of Care______________________

I ALSO GIVE CONSENT TO:____
Name

____
Address

TO RELEASE THE FOLLOWING INFORMATION **FROM DATE:______________TO____________**

_______Psychiatric Evaluation(s) _______Medications _______Probation Information
_______Psychiatric Note _______Laboratory Results _______Court's Recommendations
_______Psychological Testing _______Discharge Summary _______School Transcriptions
_______Social History _______Treatment Recommendations _______Academic performance Record
_______Mental Health Assessments _______Daily Living Behavior _______Individualized Education Program
_______Hospital Records _______Financial Information _______Employment History
_______Other medical ___________ _______Entitlement Benefits _______Vocational/Educational Plans

TO: **Union County Counseling Services, Inc.,** 204 South Street, P.O. Box 548, Anna, IL 62906
Fax :(618)833-2911 Phone:(618)833-8551

FOR THE PURPOSE OF: _______Coordination of Services and/or Continuity of Care_________

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1. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information to be disclosed.
2. I understand that I may revoke this authorization at any time (revocation must be in writing) except to the extent that action has been taken on this authorization.
3. I further understand that this authorization will expire without my revocation on_______________________
4. I further understand that the person or persons who receive this information, in accordance with State and Federal regulations, will not disclose this information without further written consent.
5. It has been explained to me that if I refuse to consent to the release of information specified above, the following consequences occur: **information will not be released or obtained.**
6. I have read, or had read to me, the above and agree to and understand the contents.

____ ____
Consumer (age 12 or older) Date Witness Date

____ ____
Parent/Guardian Date Witness** Date

* If the consumer is a minor, signature of a parent or guardian is required
** If unable to write his or her name, the consumer should enter an "X" or other mark. A signature of second witnesses is required when the "X" signature is used.

NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (Ill. Rev. Stat., Ch. 91 ½, par. 801 et seq.) (740 ILCS 110/1 et seq.), you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July 1, 1975, Confidentiality of alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.