AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION*

North Shore Counseling, Ltd.
Office & Mailing Address: 425 Huehl Rd., #19B, Northbrook, IL 60062
Phone: (847) 205-0371 **Fax:** (847) 205-0377

Client's Name: _____ Birth Date: _____

If client is a minor, person authorized to grant authorization:

Name:_____ Relationship to Client: _____

I authorize Victoria Fleming, Ph.D., LCPC, and her North Shore Counseling, Ltd., associates and employees to share & receive confidential record information with & from the following person, people, and/or agencies:

Name	Phone & Email	Address

Information shall consist of: Duplicate records and/or verbal consultation concerning treatment and/or education. Specifically:

- ☐ **All Clinical Records**
- ☐ Psychological Evaluation
- ☐ Educational Evaluation
- ☐ Medical History
- ☐ Social History
- ☐ Discharge Summary
- ☐ PCP Contract Form
- ☐ Master Treatment Plan
- ☐ Psychiatric Evaluation
- ☐ Mental Health Info
- ☐ Drug/Alcohol tests & results, diagnosis, treatment info
- ☐ Other: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate one year from the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information**) may be protected by Federal Regulations.
**Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

_____ _____
Signature of Client or Legal Representative Date Witness Date

☐ I do not give my mental health provider permission to contact anyone beyond their legal responsibility as a mandated reporter in the State of Illinois.

_____ _____
Signature of Client or Legal Representative Date Witness Date

*PRIVACY ACT STATEMENT

1. The authority for soliciting the information comes from 10 USC 3012
2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.
3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed.
4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.