A.H.D.C.

Release of Information

Associates in Human Development Counseling, LLC

1240 W. Northwest Highway • Palatine, IL 60067 • Ph: 847-483-0800 • Fax: 847-483-0540

Authorization to Release Information

I, the undersigned, hereby give permission to have Associates in Human Development Counseling, LLC, release pertinent information regarding _____
to _____
This information is needed in order to facilitate treatment. The nature of the information to be disclosed is as follows: (1) confirmation of participation, including attendance at scheduled service; (2) treatment recommendations; (3) recommendations for other service modalities.

Authorization to Request Information

I, the undersigned, hereby give permission to have _____
release pertinent information regarding _____
to Associates in Human Development Counseling, LLC. This information is needed in order to facilitate treatment. The nature of the information to be disclosed is as follows: (1) Information regarding reason for referral; (2) information on past treatment history and concurrent treatment recommendation.

The person or agency to whom information is disclosed may not re-disclose this information unless I specifically consent to such re-disclosure. I understand I have the right to inspect and copy the information to be disclosed. This consent is valid until: _____. I understand that I have the right to revoke this consent at any time. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility named herein.

Signed: _____ Date: _____

Printed: _____ Date: _____

Guardian (if client is a minor): _____ Date: _____

Witness: _____ Date: _____