Beyond Healing - A Counseling, Wellness & Personal Growth Center, Inc
13728 W. Carefree Dr. Homer Glen Il 60491 (708) 837-3722

Authorization for Release of Information

Name: _____ **Date of Birth:** _____ **Student ID#:** _____
Address: _____ **City, State, Zip:**_____**Phone Number:**_____

☐ **I authorize Beyond Healing Counseling Center to release information to:**

AND/OR

☐ **I authorize the Beyond Healing Counseling Center to obtain information from**

_____ **Name of Provider or Facility**

_____ **Address**

_____ **City, State, Zip Code**

_____ **Phone #IFax # (Include area code)**

_____ **Name of Provider or Facility**

_____ **Address**

_____ **City, State, Zip Code**

_____ **Phone #IFax # (Include area code)**

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED:

☐ **Psychiatric/Psychological Evaluation and/orTreatment** ☐ **Drug/Alcohol Evaluation and/orTreatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:**_____ ☐ **Diagnostic Impression**
☐ **Discharge Summary** ☐ **Treatment Plans** ☐ **Treatment Summary** ☐ **Other: (please describe)**_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:

☐ When the requested information has been sent/received
☐ 90 days from this date. ☐ Other:.

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

☐When I am no longer receiving services from Beyond Healing Counseling Center.
☐ One year from this date. ☐ Other:

I understand that:

☐ I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
☐ I may cancel this authorization at any time by submitting a *written* request to Beyond Healing Counseling Center, except where a disclosure has already been made in reliance on my prior authorization.
☐ If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
☐ If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
☐ Release of HIV-related information requires additional information.
☐ If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Client or Representative:_____Date:_____
Relationship to Student *(if requester is not the client):* ☐ Parent ☐ Legal Guardian ☐ Other:.
Patient or Representative has been provided a copy of this authorization: _____(*Staff member providing copy)*
Revised 08/19/08