The Self-Care Path, LLC
1333 Burr Ridge Parkway, Suite 200
Burr Ridge, Illinois 60527
Phone: 708-429-0353
Fax: 386-263-8326
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RELEASE OF INFORMATION

You only need to fill out this form if you need your provider to disclose information about your counseling to someone or some group of your choice. This also must be filled out for SCP-Therapists to consult regarding your case.

CONSENT FOR RELEASE OF INFORMATION

1. I,_____ (print your name), born: _____(DOB)

2. hereby give consent to: _____(print your provider's name), of The Self-Care Path, LLC at 1333 Burr Ridge Pkwy Suite 200, Burr Ridge, Illinois 60527 on this date: _____via: __ Phone: _____

   __ Fax: _____

   __ Email: _____

   __ Meeting/Date: _____

   __ Mail: (see address below, in line #4)_____

3. to release information concerning: _____
   Also, check the information your provider may release:

   _____Intake/Initial Behavioral Health Assessment (this includes all personal background info, including but not limited to personal history, education, mental health, medical health, social history, financial history, and other information your provider collected from you at your initial appointments). You may choose to circle information to release, and X out information not to release.

   _____Progress Notes (indicate date range if not all sessions): _____

   _____A Letter, as requested of my therapist, dated: _____

   _____Other Information, as noted: _____

4. to: _____(print person/business)
   at the following address:

   _____

   _____

   _____

5. The reason for requesting this information is: _____

6. _____ (Initials) Disciplinary action OR treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether the consent is signed by the client or his/her personal representative. In other words, information may not be released by your provider even if you signed this consent if your provider believes you signed ANY release forms as a disciplinary action OR as a condition of treatment, payment, enrollment, or eligibility for benefits by another third party (including your employer). Furthermore, the information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information.

7. HOWEVER, I, _____ (print your name) UNDERSTAND THAT IF I REFUSE TO CONSENT, THE FOLLOWING MAY HAPPEN:

    a. _____
    (if you need more space, please write on the back of this form)
    b. I understand that I have the right to inspect and copy the information that would be disclosed.
    c. I understand that my provider will discuss whether item 7b is indicated or contraindicated to my treatment plan. If my provider considers my review of the information as contraindicated, and I review it anyway -I understand that I may ask my provider or another licensed mental health professional to help me understand my file's contents.

8. _____ (Initials) I understand that I may revoke this consent at any time by notifying the provider of information listed in Line 2 above in writing. Revocation will be effective except to the extent that action has been taken in reliance on this consent. I also understand that, even if I do not revoke this consent, the consent will expire one year from the date provided on line 2 unless an earlier date is specified.

*****IF CLIENT IS A MINOR or HAS A GUARDIAN, COMPLETE THIS SECTION, #9, 10, 11*****

9. Signature of Minor, aged 12 to 17 years of age: _____

    Print Name of Minor: _____ Date Signed: _____

10. Further, I ,_____, the parent, or the legal guardian or custodian, appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the individual minor, _____, and I hereby consent to this limited disclosure under the terms stated above. The legal guardian or custodian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

11. Signature of Parent, Guardian, or Authorized Agent: _____

    Print Name of Agent: _____ Date Signed: _____

    Address of Agent: _____

    _____

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12. Signature of Agent Consenting to Release of Own Records: _____

    Date Signed: _____ Date consent expires: _____

13. Signature of Witness: _____ Date Signed: _____

    Relationship if not provider: _____

    Address of Witness if not provider:

    _____

    _____

    _____