kp counseling

6392 Linden Road
Rockford, IL 61109
Ph: (779) 368-0060
Fax: (779)-368-0579

Request/Authorization to Release Confidential Records and Information

Client Name:_____

D.O.B.:_____ SSN:_____

I hereby authorize kp counseling at the address and phone number shown above
☐To release to and/or ☐Get information from:

Person or Facility:_____

Address: _____ Phone:_____

_____ Fax:_____

_____

This information to come from medical/therapy records for the purposes of further mental health evaluation, treatment, or care.
Treatment dates:_____

The information to be disclosed is marked by an X in the boxes below.

- ☐ Intake and discharge summaries
- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Treatment summary
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes
- ☐ Other:_____

Please forward the records to the address in the letterhead at the top of this form.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically 12 months from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian	Printed name/Relationship	Date
_____	_____	_____
Signature of witness	Printed name	Date

☐ Copy for client or parent/guardian ☐ Copy for source of records ☐ Copy for recipient