

Myers
Counseling
Group, Ltd.

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CONFIDENTIAL STATEMENT OF RELEASE

I hereby authorize _____ to release and/or exchange of
(Myers Counseling Group)

information with _____ (clinician) as initialed:

Initial work-up Psychological test reports Psychiatric evaluation
 Summary of contacts Urinalysis test results Other _____

For the purpose of: Facilitation of care

I hold harmless _____ \Myers Counseling Group, in regard to use of information authorized for release or exchange. This release expires 60 days after termination of services or at the discretion of the signed party. I have the right to cancel this release at any time, however, cancellation does not affect past action. I understand that I have the right to inspect and copy the information to be disclosed. It is understood that a refusal to authorize the release of the information specified above will prevent to disclosure of such information to the organization identified above, which may result in your not receiving the level of service you need.

Printed Name of Patient: _____

Social Security : _____ Birth date: _____

Signed: _____ Date: _____

Signature of Parent or Guardian _____
(if 18 years of age or under)

Witness: _____ Date: _____

Notice to recipient: Under Illinois and Federal Confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure.

A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical records.