SMART LOVE®
FAMILY SERVICES

Authorization to Release Information

Client's Name: _____ Date of Birth: _____

I hereby authorize Smart Love Family Services Administrative and Clinical Staff to release the following information: (check all that apply):

- ☐ Treatment Summary
- ☐ Treatment Plan
- ☐ Treatment Recommendations
- ☐ Treatment Progress Notes
- ☐ Progress Update
- ☐ Clinical Intake
- ☐ Medical Record
- ☐ Other:_____

_____ _____
Name Phone number

_____
Address City State Zip

I am requesting my therapist to release this information for the following *purpose*: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose):

_____

This authorization shall remain in effect from _____ until _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date