CHADDOCK

CONSENT FOR RELEASE OF INFORMATION

Client Name: ___________________ **Date of Birth:** ______________________

I hereby authorize Chaddock and ____
(Person/Agency)

____
(Street) (City) (State) (Zip) Phone Fax

to exchange information regarding the above-mentioned client.

The following information is to be released and/or exchanged:

Discharge Summary
Physician Progress Notes
Psychiatric Evaluation
Psychological Evaluation
Immunizations

Physical Examination
Social Assessment
Hearing and Vision Exam
Individual Education Plan (IEP)
School Transcript

Court Reports
Social History
Progress Reports
Other: ____________________
____

Mental health and/or alcohol and drug abuse records, if any, will be disclosed as a part of the complete medical record unless a note is made not to disclose the information. Information about HIV/AIDS status will be disclosed only at the request of the client.

The purpose for which this disclosure is being made is: ____
____

Notice of Rights:
I understand that I have the right to inspect and copy the information that is to be disclosed. I also understand that if I refuse to consent to the disclosure of my records, they will not be disclosed and I will not incur a penalty. I further understand that I have the right to revoke this authorization at any time by notifying Chaddock in writing. Information to be released may include both paper and electronic records.

This authorization expires 1 year after the date of the authorized signature shown below for ongoing service provision, unless an earlier expiration date is indicated.

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, with the exception of reports and other information that is required to be released to the court and certain parties to juvenile court proceedings as authorized by the Juvenile Court Act, 705 ILCS 405.

_______________________________ _______________________
Client Signature (12 years or older) Date

☐ **Own Guardian**

Date Consent Expires: ________________

_______________________________ _______________________
Witness (Parent) Signature Date

☐ Copy received ☐ Copy declined
☐ Guardian notified of need for signature. Date: _____

_______________________________ _______________________
Witness (Staff) Signature Date

This authorization must be signed by the client. If the client is a minor, and the records do not contain information about mental health, alcohol/drug abuse, or venereal disease, this authorization may be signed by the minor's parent or guardian. If the client is a minor, and the records pertain to mental health treatment, alcohol/drug abuse, or venereal disease, this authorization must be signed by the minor. If the client is mentally incompetent to sign this authorization, it must be signed by the appropriate legal representative of the client.

Revocation of Permission:
Permission revoked on _______________________________ _______________________________
Date Signature

____
Witness Signature

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