Hawthorn Counseling Group
1580 South Milwaukee Avenue, Libertyville, IL 60048 (847) 680-0755 • www.hawthorncounseling.com

Authorization to Release Information

This form, when completed and signed by the patient or parent/guardian, authorizes the Hawthorn Counseling Group clinician indicated below to release protected health and mental health information to the person or organization designated

Patient Name: _____ D.O.B.: _____

I authorize the following clinician with Hawthorn Counseling Group**, John D. Jochem, Psy.D.,** to release the following information: (Patient/Client should initial each item to be disclosed)):

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Billing Information
_____Toxicology Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes
_____ Verbal Exchange of Information
_____ Other: _____
_____
_____

This information should only be released to (name & address of person/organization to whom the information is to be released): _____

_____.

I am requesting this information be released for the following reason(s): _____

_____.

Patient Name: _____ D.O.B.: _____

This authorization shall remain in effect until _____/_____/_____. (If no calendar date is stated, the information can be released only on the date on which the authorization is received by Hawthorn Counseling Group).

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Hawthorn Counseling Group. However, any such revocation will not be effective to the extent that Hawthorn Counseling Group has already taken action in reliance upon this authorization or if this consent was obtained in connection with processing of health insurance claims and the insurer has a legal right to contest a claim.

I understand that if I refuse to consent to this authorization, the consequences of my refusal, if any are as follows: my mental health records and/or communications will not be disclosed.

I understand that I have the right to inspect and copy the disclosed mental health records and communications 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. However, I understand that Hawthorn Counseling Group has no control over the risks of redisclosure by the recipient of this authorization and agree to hold Hawthorn Counseling Group harmless for such a possibility.

_____ _____

Patient Signature Date Guardian Signature (if applicable) Date

_____

Witness Date