HeartLAND COUNSELING CENTER, INC.
2320 Dean Street, Suite 102
St. Charles, IL 60175
P: 630.443.9100 F: 630.443.9101
www.heartlandcounseling.org

When this form is completed, signed and witnessed, it authorizes Heartland Counseling Center, Inc. Staff to receive, release, and/or exchange protected mental health information from your clinical record to the person or agency you designate.

Name of Client: _____ Date of Birth: _____

Client Full Address: _____

Client Telephone: _____

I hereby authorize staff at Heartland Counseling Center, Inc (2320 Dean Street, Suite 102, St. Charles, IL) to: (choose one)

_____ RELEASE information TO the following person or institution OR
_____ RECEIVE information FROM the following person or institution OR
_____ EXCHANGE (both release and receive) information with the following person or institution

Information may be released, received, or exchanged with:

Name of person or institution: _____

Address: _____

Information may be disclosed or obtained by: (please check all that apply) ☐ Mail ☐ In Person

☐ Phone: _____ ☐ Fax: _____ ☐ Email: _____

unless restrictions in manner of exchange are noted here: _____

The purpose of this information disclosure or exchange is: (please check at least one)

☐ At the request of the patient or guardian ☐ Coordination of care ☐ Other: _____

Please check the following information you authorize to be released: (check all that apply)

☐ Attendance and treatment dates	☐ Initial evaluation/assessment	☐ Treatment plan	☐ Treatment summary (ongoing)
☐ Progress/case notes	☐ Psychological Assessment/Test	☐ Diagnoses	☐ Recommendations
☐ Discharge summary	☐ IEP and/ 504 plan	☐ Psychiatric evaluation	☐ Substance use information
☐ Drug and alcohol assessment	☐ Drug and alcohol treatment info	☐ Medical Records	☐ Eligibility and Benefits

☐ Other: _____

This authorization is valid until calendar date: (MONTH/DATE/YEAR) _____

I understand that I have the right to inspect the disclosed mental health information at any time. I further understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization by a plan or provider covered by HIPAA privacy regulations unless this authorization specifically authorizes such redisclosure. However, if the entity receiving this information is not a healthcare provider or plan covered by HIPAA privacy regulations, I understand that the information described above may be re-disclosed and no longer protected by HIPPA regulations

I understand that I may revoke this authorization *in writing* at any time; I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communication until it is received by the person otherwise authorized to disclose records and communication. I further understand that the revocation will not effect actions taken before the Heartland Counseling Center, Inc. receives written notice or to the extent that Heartland Counseling Center, Inc. has taken previous 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 contest a claim. Revocation notification should be addressed to: Heartland Counseling Center, Inc. 2320 Dean Street, Suite 102, St. Charles, IL 60175

I understand that my mental health provider generally may not condition services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party.

Refusal to sign this form will result in the following consequences: Information will not be disclosed or obtained except for according to the Illinois mental health code, state and/or federal law, and/or the Heartland Counseling Center, Inc. HIPPA policies.

A copy of this authorization that shows my signature is as valid as the original release signed by me. This authorization must be witnessed to be legally valid.

Date	Signature of client (required if 12 years or older)	Printed Last Name
Date	Witness to client signature (REQUIRED)	Printed Last Name
Date	Signature of Parent, Guardian or Legal Patient Representative	Printed Last Name and relationship
Date	Witness to Parent/Guardian/Legal Representative Signature (REQUIRED)	Printed Last Name

NOTE TO RECEIVING AGENCY/FACILITY/PERSON: Under the provisions of the Illinois Mental health and Developmental Disabilities Confidentiality Act, you may not redisclose any records disclosed pursuant to said Act unless the person who consented to this disclosure specifically consents to such redisclosure.