LODESTONE

CENTER FOR BEHAVIORAL HEALTH

15 Spinning Wheel Rd
Suite 426
Hinsdale, IL 60521
P. 630.323.3050
F. 630.323.3058

1011 Lake St
Suite 421
Oak Park, IL 60301
P. 630.323.3050

3923 Mercy Dr
Suite F
McHenry, IL 60050
P. 815.344.5061

111 Dean St
Woodstock, IL 60098
P. 815.344.5061
F. 815.344.5072

645 N Michigan Ave
Suite 1005
Chicago, IL 60611
P. 815.344.5061

Request/Authorization to Release Confidential Records and Information

I hereby authorize:

The LodeStone Center for Behavioral Health to release information from records about:

_____, _____
(name of client) (date of birth)

for the following purpose(s)
[ ]Further mental health evaluation, treatment, or care
[ ] Rehabilitation program development or services
[ ] Treatment planning
[ ] Research
[ ] Other: _____

Receiving Party:

Name: _____

Phone: _____

Fax: _____

Email: _____

Address: _____

These records include time between the dates of _____ and _____.

Only the information with an X through the box below will be released:

[ ] Intake and discharge summaries
[ ] Medical history and evaluation(s)
[ ] Mental health evaluations
[ ] Developmental and/or social history
[ ] Educational records
[ ] Psychological Evaluations
[ ] Progress notes, and treatment or closing summary
[ ] Other: _____

I have a right to inspect a copy of any and all materials that will be disclosed.

Should I refuse to disclose, the consequence could be:
_____
_____

Select One:
[ ] Please forward the records to The LodeStone Center at the Woodstock address at the top of the front of this form.
[ ] Please forward The LodeStone Center records to the address written under “Receiving Party.”

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except in the event that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____

Printed name of patient

_____ _____

Signature of patient Date

_____ _____

Signature of Parent or Guardian Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent but was physically unable to provide a signature.

_____ _____

Signature of witness Date

[ ] Copy for patient or parent/guardian [ ] Copy for source of records [ ] Copy for recipient of records