Phoenix Rising Solutions, LLC
to educate, empower, & enlighten

Authorization for the Release or Exchange of Information

I, _____
(Client Name) (Date of Birth) (SS#)

request and authorize Jennifer Falbo-Negron, LCPC dba Phoenix Rising Solutions, LLC of 2205 Point Boulevard, Suite 125, Elgin, IL 60123 (630) 526-4325-phone and (630) 318-3210-fax to

☐ Exchange with ☐ Receive from ☐ Provide to

_____

_____
(Name, Address, Phone, & Fax of Agency or Person to Provide or Receive Information)

Having been fully informed of the circumstances in connection with this request, I hereby request and authorize you to disclose the information below in your record of service provided to me (or my child _____).

Information to be released (in written and/or oral form):

☐ Admission/Discharge Information
☐ Medical Record/History
☐ Progress Notes
☐ Treatment Summary
☐ Psychological/Psychiatric Evaluation
☐ Educational History/School Report
☐ Social History
☐ Other (Specify):

I hereby have the right to inspect and copy the information to be disclosed. The consequence of refusal to consent is that no information can be released. I understand that I do not have to sign this authorization.

Purpose of Disclosure:

☐ Assisting with the client's assessment and treatment plan
☐ Continuity of care or discharge planning
☐ At the request of the client/client representative
☐ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has already been taken on this authorization. The revocation must be in writing and received by the person releasing the information. I further understand that this authorization shall expire on _____ or 12 months after the date of my signing this form.

I understand that information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information. I understand that the information received cannot again be given to any other agency or person without my written consent.

Notice to Receiving Agency/Person:
Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

_____
Client Signature (Parent signs for clients under the age of 12 years old) Date

_____
Both client and parent/guardian signature is required if the client is between 12 and 18 years old Date

_____
Jennifer Falbo-Negron, LCPC / Witness Date