LEE JACOBS RIGGS, LCPC
P 773.797.2261 **E** LJACOBSRIGGSLCPC@GMAIL.COM

CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, whose Date of Birth is: ____/____/_______, hereby authorize and
(Please print full legal name)
request Lee Jacobs Riggs, LCPC to release to/obtain from/discuss with

____the following (*Check all that apply)*:
(Name of Person or Organization)

☐ Biopsychosocial Assessment	☐ Educational Information	☐ Continuing Care Plan
☐ Psychological Assessment	☐ Discharge/Transfer Summary	☐ Progress in Treatment
☐ Psychiatric Report	☐Treatment Plan	☐ Current Treatment Update
☐ Diagnosis	☐ Presence/Participation in Treatment	☐ Medical Information
☐ Medication	☐ Toxicological Reports/Drug Screen	☐ Nursing Information
☐ Other ________________	☐ Other ________________________	☐ Other ________________

Address of Above Named Person or Organization: ____
____
Phone: ____Fax: ____

I understand that:

The purpose of this disclosure of information is to improve evaluation and treatment-planning, share information relevant to treatment, and, when appropriate, coordinate treatment. If for another purpose, please specify: ______________________
____

My records are protected under the *Federal Confidentiality Regulations* and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

Redisclosure of this information to another person or agency is forbidden under the provisions of the Illinois *Mental Health and Development Disabilities Confidentiality Act*, unless consent for redisclosure has been specifically provided

I may revoke this consent at any time, but not retroactive to the prior release of information made in good faith. If I decide to revoke this authorization, such revocation must be in writing and signed, dated and witnessed.

I have the right to inspect and copy information to be disclosed and I will be given a copy of this authorization if requested.

This authorization expires on _____/_______/_______. If no date is specified, this authorization is valid until one year from the date signed.

Signature of Client:____ Date:__________________

Signature of Guardian:____ Date:__________________
(required if client is under 12 years of age or has been adjudicated incompetent)

Relationship to Client: ____

Signature of Counselor:____ Date:__________________