CLINICAL CARE CONSULTANTS
Counselors Who Care

Release of Information Consent

I, _____, hereby authorize _____ of
Clinical Care Consultants located at 1642 West Colonial Parkway, Suite 100, Inverness, IL 60067
phone: 847-749-0514 fax: 847-221-8040 to:

[ ] disclose information to [ ] receive information from [ ] exchange information with

Name(s): _____ **Phone #:** _____

Name or Agency Name: _____

Address: _____
(street) (city) (state) (zip)

Client's Name: _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

The Following Information is either requested or will be shared
[ ] Treatment Progress [ ] Recommendations [ ] Case Summary

_____
_____
__

The above information will be used for the following purposes:
[ ] Coordination of Care [ ] Case Collaboration

_____
_____
____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary. If not previously revoked in writing, this consent will terminate on _____. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: Self ____ Parent/legal guardian ____ Representative _____ Other: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____

Parent/guardian/personal representative (if applicable)
Signature: _____ Date: _____/____/_____

Witness (if client is unable to sign)
Signature: _____ Date: _____/____/_____