125 W. 55th St., Suite #200, Clarendon Hills, IL, 60514 | www.petrohiloscounseling.com | 630-286-2785

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Petrohilos and Associates Counseling, LLC to release and disclose information from the clinical record of:
____ (__________) to, and allow such information to be inspected and copied by:

____

(Facility/Individual/Provider)

____

(Address)

Nature of information to be disclosed:____

____

For the purposes of:
____

____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Petrohilos and Associates Counseling, LLC. I understand that a revocation is not valid to the extent that Petrohilos and Associates Counseling, LLC has acted in reliance on such authorization. This authorization is valid until ______________ (Date).

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _________________________no information released and/or

____

A copy of this release shall have the same force and effect as the original.

____________________________ ____________________________
Client Signature Date

____________________________ ____________________________
Parent/Legal Guardian Signature Date
(if client is a minor)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.