Consent for Release of Information

I request and authorize the individual, health care professional, agency, hospital or medical center listed below to release the information specified to

Birch River Wellness, PC
Pamela Bell, LCSW
4633 N. Western Ave., Suite 201
Chicago, IL 60625
(312) 203-3405

Name, address, phone number and fax number of organization or individual who is to release information:
_____

_____

Information or communication requested:_____

_____

I also authorize Birch River Wellness, PC/Pamela Bell, LCSW to provide written and/or verbal information regarding my mental health treatment to the organization or individual above.

Purpose of release of information: at the request of the individual below

The statues that govern this authorization include but are not limited to: Mental Health and Developmental Disabilities Confidentiality At (740 ILCS 110), 735 ILCS 5/7/2001(inspection and copying of hospital records and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

I understand that I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing, at any time by sending such written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my social worker may not condition psychological services upon my signing an authorization unless the psychological services are provided to me or the purpose of creating health information for a third party. Refusal to sign this form will result in the following consequences: information will not be disclosed/obtained.

It is my full understanding that the records and communications disclosed WILL include sensitive information such as evaluation, treatment for mental health, developmental disabilities, alcohol or substance use/ abuse or HIC/AIDS unless specifically checked below for exclusion:

___Alcohol?Substance Abuse ___HIV/AIDS ___Mental health ___Developmental disabilities
___Other_____

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may have a copy of this form at any time that I choose to request it. The authorization will automatically expire on the date specified here_____

_____ _____
Full Printed Name of Client Signature

_____ _____
Date of Birth Address

_____ Today's Date