Authorization to Release Information

Robert J. Smith, LCSW

241 *Golf Mill Center, Suite 708, Niles, Illinois 60714*

Ph. (847) 824-8366 *Fax.* (847) 824-8367

I, (name of patient)_____, (hereinafter "Patient") hereby authorize Robert J. Smith. LCSW, (hereinafter "Provider") to disclose and receive mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, provider's diagnosis of Patient, with:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at (241 Golf Mill Center, Suite 708. Niles, Ilinois 60714) to be effective.

This disclosure of information and records authorized by Patient is required for Continuity of Care. The specific uses and limitations of the types of psychotherapy information to be discussed are as follows: Evaluation and Treatment Plans. Such disclosure shall be limited to the following specific types of information if any:

_____

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Refusal to sign this form may lesson the possibilities of positive treatment outcome or interfere with continuity of care. Provider also may choose not to provide treatment to the Patient.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Illinois law may protect such information.

This authorization shall remain valid until:_____ _

Patient's Signature:_____Date:_____ _

Witness's Signature:_____Date:_____