Glenview Counseling Group, LLC
3633 W. Lake Ave.
Suite 105
Glenview, IL 60026
(847)699-2490

Release of Information

Client Information

Name _____ Date of Birth_____
Home address _____ Zip_____
Phone: (Work)_____ (Home)_____ (Cell)_____

I authorize Glenview Counseling Group and its associates to release information to and from:

Name _____Company_____
Address _____
Phone: _____ Fax: _____ Other: _____

Regarding any and all of the following information concerning my care. This authorization expires on ___/___/_____.

- ☐ In person (verbally)
- ☐ By phone (verbally)
- ☐ By written report—faxed, emailed, or mailed

Check all that apply:

- ☐ Any and all clinical information
- ☐ Intake/assessment
- ☐ Dates of treatment
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Client status and progress report
- ☐ Other _____

For the purpose of:

- ☐ Continuity of care
- ☐ Disability determination
- ☐ Evidence of care
- ☐ Aftercare services
- ☐ Reimbursement for treatment
- ☐ Other _____

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences:

- ☐ Records in question will not be disclosed
- ☐ My insurance company will not be billed and I will forgo using insurance
- ☐ Other: _____

I understand that I have a right to inspect and copy the information to be disclosed.

I understand that I may revoke this consent at any time by giving written notice, except to the extent that Glenview Counseling Group has already taken action in reliance on it.

_____ _____
Client's signature (age 12 and older) Date

_____ _____
Parent/guardian of minor OR of legally disabled recipient Date

_____ _____
Witness signature Date