kellie rice, lcpc, ltd.
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Mind Body Co-op
30 N Michigan, Suite 424
Chicago IL 60602-3844
312-279-9981

# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I understand my records contain information about my therapy sessions and my mental health. I understand all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

Name of Client _____ Date of Birth:

I hereby give consent to _____ (Name of therapist) at Mind Body Co-op to exchange pertinent and relevant information with the individual/agency identified below.

Name: _____

Agency: _____

Street: _____

City/State/Zip: _____

Phone: _____

Fax:_____ Email:

Information obtained may include (Check all that apply):

- ☐ Clinical Impressions and Records
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Academic Records Health
- ☐ Records Social Work
- ☐ Evaluations
- ☐ Other:

- ☐ I understand this release will expire 90 days from the date it is signed
- ☐ I understand that I have the right to revoke this release at any time.
- ☐ I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, an the implications of their release. I submit this request voluntarily.

Client/Parent Signature: Date:

Print Name:

Relationship to Client_____ Dates Effective: to