Associated Clinical Psychologists, Ltd.
1580 N. Northwest Highway, Suite 311D
Park Ridge, Illinois 60068
(847)824-1235

To Whom It May Concern,

Illinois law prohibits the release of mental health records without a properly executed Mental Health Release Form, which is enclosed.

In order to facilitate the release of information you requested, we require the patient/legal guardian's signature on the enclosed release form. Please make sure the form is filled out completely; including the patient information, the recipient of the information, and exactly what information is to be released. Also make sure that all relevant signatures are present. Illinois law requires that a patient over the age of 12 must authorize a release of mental health information. Please note that the release is only valid if it is witnessed by a ***non-family member***. When all of the above have been completed, please send ***the original copy*** (**please do not fax this document)** back to Associated Clinical Psychologists, Ltd. and we will then be able to process the release of information that you have requested.

Please note that you will need to complete a separate consent to release information form for each individual or organization you want information to be released to.

Thank you for your cooperation.
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RELEASE OF INFORMATION FORM

NAME OF PATIENT:_____

DATE OF BIRTH:_____/_____/_____ AGE:_____

ADDRESS:_____

I/WE HEREBY AUTHORIZE: **ASSOCIATED CLINICAL PSYCHOLOGISTS, Ltd.**

TO RELEASE TO/REQUEST FROM:
ADDRESS:
PHONE:

THE FOLLOWING INFORMATION FOR THE PURPOSES OF TREATMENT PLANNING

_____HEALTH/MEDICAL RECORDS

_____EDUCATIONAL RECORDS

_____CONSULTATION WITH CLERGY

_____SOCIAL HISTORY

_____PSYCHIATRIC EVALUATIONS

_____NEUROPSYCHOLOGICAL EVALUATIONS

_____PSYCHOLOGICAL ASSESSMENTS AND DIAGNOSIS

_____PRIOR TREATMENT RECORDS AND REPORTS

_____OTHER (PLEASE SPECIFY)

I/WE UNDERSTAND THAT I/WE HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. I/WE UNDERSTAND THAT I/WE MAY REFUSE TO CONSENT TO DISCLOSURE PRIOR TO THE INFORMATION BEING SENT. I/WE UNDERSTAND THAT INFORMATION MAY BE TRANSMITTED VIA TELEPHONE, MAIL OR FACSIMILE.

I/WE HAVE READ THE ABOVE AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS CONCERNING THIS CONSENT, **INCLUDING THE CONSEQUENCES, IF ANY,** OF REFUSAL TO CONSENT. THIS CONSENT IS VALID FOR SIX MONTHS FROM THE DATE IT IS SIGNED.

_____ _____/_____/_____
PATIENT SIGNATURE DATE
AGE 12 AND OLDER MUST SIGN

_____ _____
PARENT/GUARDIAN WITNESS

THIS RELEASE EXPIRES SIX MONTHS FROM DATE SIGNED