Alliance Counseling & Coaching of Illinois, LLC

25224 W. Eames St. Channahon, IL 60410 (Main Office)

phone: 815-467-8181 fax: 815-828-5696

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name (printed): _____ **Date of Birth:** _____

Other Names Used: _____Phone: _____

Parent/Guardian/Legal Representative Name (minors only):_____

Health Care Provider, Person, Agency or Emergency Contact Information: Please provide the name and contact information of the provider, person, agency or emergency contact (outside of Alliance Counseling) with whom Alliance Counseling & Coaching will exchange the information indicated below.

_____

Physician/Provider, Person, Agency or Emergency **Contact Name** **Relationship to Client (**e.g. PCP, Mother, etc.)

_____

Physician/Provider, Person, Agency or Emergency Contact **Street Address, City, State, Zip**

_____

Physician/Provider, Person, Agency or Emergency Contact **Phone** **Fax**

I authorize Alliance Counseling & Coaching of Illinois, LLC to communicate the following types of information from the provider, person or agency listed above by:

___Sending the information indicated below;
___Requesting the information indicated below; and/or
___Communicating the information as needed for purposes identified below.

Please indicate the ***type of information*** to be released **(check all that apply**):

___Documentation from a specific program or provider:
Program/Provider Name: _____
___Intake Evaluation/Diagnostic Assessment
___Individual Therapy Documentation/Progress Notes
___Treatment Plans
___Discharge Summaries
___Ongoing Verbal Communication
___Other (please specify) _____

Please indicate the ***purpose*** of the release of information (check all that apply):

___Coordination of Care ___Discharge and Continuation of Care ___Client Request
___Insurance ___Litigation/Legal Purposes ___Other (please specify) _____

___In addition, I authorize Alliance Counseling & Coaching of Illinois, LLC to disclose my protected health information to this individual as my Emergency Contact in situations in which Alliance Counseling & Coaching, LLC perceives a threat to my health, safety or well-being.

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Statement of Authorization: I understand that I may revoke this consent at any time by providing written notice to Alliance Counseling & Coaching of Illinois, LLC and that **after one year this consent automatically expires.** I have been informed what information will be released, its purpose and who will receive the information and I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand and authorize that the disclosure may include information on mental health diagnosis and treatment, AIDS or HIV infection, drug or alcohol abuse or genetic testing. I understand that personal health information, once disclosed, might be re-disclosed and is no longer protected by federal privacy regulations. I also understand that I may refuse to sign this authorization. Alliance Counseling & Coaching of Illinois, LLC will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization. ***BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM.***

_____

Client Signature (required if client is 12 years or older) Parent/Guardian/Representative Signature Date

Legal Representative (required for clients under the age of 18 years): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

_____

Parent/Guardian/Representative Signature Relationship to Client/Legal Authority Date

Revised: January 8, 2014
Original: Client File
Copy: Client