JEFFREYCIOLINO

Licensed Clinical Professional Counselor
(773) 905-9805 | JeffreyCiolino@gmail.com | JeffreyCiolinoLCPC.com

Release of Information Consent

I, _____, authorize Jeffrey Ciolino, LCPC, to release and/or obtain the following information:

- ☐ Medical Reports
- ☐ Testing Reports
- ☐ Treatment Plans
- ☐ Verbal Communication that is relevant to psychological treatment
- ☐ Psychotherapy Notes* (A separate authorization, as defined by HIPPA, is required for psychotherapy notes.)
- ☐ Entire Record, except Psychotherapy notes
- ☐ Other:_____
- ☐ Other:_____

This information should only be released to:

_____
_____
_____
_____

Purpose for disclosure:

- ☐ Planning or determining appropriate treatment
- ☐ Continuing appropriate treatment
- ☐ Determining eligibility for benefits or program
- ☐ Professional Consultation
- ☐ Other:_____
- ☐ Other:_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

I understand that this authorization is voluntary and I may revoke this authorization at any time by giving written notice, except to the extent this request has already been fulfilled. Additionally, my revocation will not be effective if this authorization was obtained as a condition of receiving insurance coverage and the insurer has a legal right to contest a claim. After (**6 months**) from the below date this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization and inspect the disclosed mental health information at any time. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____

Parent/guardian/witness/personal representative (if applicable)

Signature: _____ Date: _____