Fox Clinical Services

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Foxclinicalservices.com

Consent to Release Information

I authorize Fox Clinical Services, LLC or my clinician, ________________________________,
to **release and/or exchange the following information regarding** (client name)

________________________________**:**

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(State specific nature of information to be disclosed.)

This information should only be released to and/or exchanged with:

Name: ____

Phone: ________________________________ Fax: ___________________________

Address: ____

Email: ____

This authorization shall remain in effect until: ________________ (month/day/year).
If no calendar date is stated, information may be released only on the day the authorization form is received by the clinician.

You have the right to revoke this authorization, in writing, at anytime. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

____ ________________

Client Signature (12 years or older) Date

____ ________________

Signature of Parent/Guardian Date

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

____ ________________

Witness Signature Date