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Consent to Release and Obtain Records

Client Name: _____ Birthdate: _____

I authorize the release of information concerning the said client to the following:

I authorize this provider to obtain information concerning said client from the following:

Name/Agency: _____

Address: _____

_____ City State Zip

Telephone: (_____) _____ Fax: (_____) _____

Please **INITIAL** each item below you wish to have released and/or discussed:

- | | |
|---|--|
| _____ *Appointment Days and Times | _____ *Treatment Summary |
| _____ Scheduling an Appointment | _____ Psychological Evaluation Report |
| _____ Billing | _____ IEP's, Special Education Records |
| _____ Court/Probation Records | _____ Work Records, HR reports |
| _____ *Verbal Communication with Provider regarding treatment | |
| _____ Other (specify) _____ | |
- *each of these items need to be checked for any hospital day program/discharge*

I understand that upon written request, I have the right to revoke this consent at any time.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

_____	_____	_____
Signature of Adult Client or Legal Guardian	Print Name	Date
_____	_____	(_____)_____
Address	City, State, Zip	Phone#

If you are the legal guardian signing on behalf of the child client please see below:

Client is _____ years of age. Any client 12 years and above must sign and date below:

_____	_____	_____
Signature	Print Name	Date
_____	_____	_____
Witness Signature	Print Name	Date

Fax on: _____ to: _____

Center for Personal Growth

Owner: Erin M Liebich, Psy.D

640 E Saint Charles Rd, Suite 212, Carol Stream, IL 60188

(630) 791-0118 billing@Center4PersonalGrowth.net Fax (630) 708-7654