NORTHERN ILLINOIS COUNSELING ASSOCIATES, P.C. (NICA)

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☐ **ONE-WAY** · ☐ **TWO-WAY**

AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION

PRINT FULL LEGAL NAME ____________________ **D.O.B** __________
ADDRESS ____________________ **CITY**__________ **STATE**______ **ZIP** __________

I, hereby, authorize NORTHERN ILLINOIS COUNSELING ASSOCIATES, P.C. (NICA), ☐ **to release to and/or** ☐ **to receive from:**

PRINT NAME OF FACILITY/AGENCY/DOCTOR/PERSON: ____________________

NOTE: This Authorization automatically extends to any and/or all associated "staff", authorized "representatives" and/or any affiliated "designees" of FACILITY/AGENCY/DOCTOR/PERSON listed immediately above and is wholly intended to facilitate prompt information exchange in the temporary, or permanent absence of any one of the listed referent(s) above.

ADDRESS ____________________ **CITY**__________ **STATE**______ **ZIP** __________
FACILITY/AGENCY/DOCTOR/PERSON CONTACT INFORMATION:
OFFICE PHONE: __________ **Ext.**____; **FAX NUMBER:** __________; **HOME PHONE:** __________
EMAIL ADDRESS: ____________________ **OTHER:** __________

The following information from my: ☐ **clinical;** ☐ **medical;** ☐ **legal;** ☐ **school;** ☐ **personnel;** ☐ **other (specify)**__________ **records:**
☐ Complete/Entire File; ☐ Pertinent File Records (in the sole, respective, discretion(s) of the releasing and/or receiving entities listed above);
☐ Psychological Evaluation; ☐ Neuropsychological Evaluation; ☐ Include All "Raw" Psychological and/or Neuropsychological Testing Data;
☐ Medical History; ☐ Current Medical Status; ☐ Psychiatric Evaluation; ☐ Report(s) (Specify): __________ ;
☐ Chemical Dependency Evaluation; ☐ Social Work/Social History Assessment(s); ☐ Educational /Staffing/IEP/504 /RTI/ Plan Report(s);
☐ Psycho-educational Report; ☐ Include All "Raw" Psycho-educational Testing Data; ☐ Vocational Assessment; ☐ Job Analysis Report;
☐ Intake Summary; ☐ Discharge Summary; ☐ Progress Report; ☐ Entire ____________________File;
☐ Other (Specify): ____________________.

<u>**NOTE:** This AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION is an unrestricted authorization for NICA to release and/or to receive important, personal, private, sensitive, possibly embarrassing and/or and highly confidential information about you and your life, whether past present and/or future, including any/or all information, but not, necessarily, limited to, reason for referral, presenting problem(s), presumed causal and/or contributory influences to your presenting and/or non-presenting problem(s) and other possible, relevant and/or rightly or wrongly speculative correlated and/or non-correlated variables, assessment, history, testing, diagnosis, treatment, course, progress, recommendations, dispositional planning, prognosis, anecdotal information, conveyance of "secrets", etc., *in the sole, respective, discretion(s) of NICA and/or the FACILITY/AGENCY/DOCTOR/PERSON (and/or their associated staff, authorized representatives and/or affiliated designees),* per above, while I was a:</u>

☐ patient; ☐ client; ☐ student; ☐ employee; ☐ other (specify) ____________________

from : ☐ date of first visit to: ☐ date authorization expires below or from: ☐ __________to: ☐ __________

The purpose of this disclosure is to facilitate continuity of care and treatment planning and/or the following:
☐ Per Above or ☐ Other (Specify)____________________

This authorization expires on [   ] and is limited to only that information that I have specifically requested to be sent to the FACILITY/AGENCY/DOCTOR/PERSON (and/or their associated staff, authorized representatives and/or affiliated designees), as checked or 'X'-ed off and/or, otherwise, listed above, unless specifically restricted, in writing, herein. The information released is not to be further disclosed or used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke, in writing and at any time, the consent contained herein. Any such revocation shall have no effect on disclosures made prior thereto. I understand I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release and/or receipt of the information specified above will prevent disclosure of such information to the FACILITY/AGENCY/DOCTOR/PERSON (and/or their associated staff, authorized representatives and/or affiliated designees) named, herein.

SIGNATURE OF FULL LEGAL NAME OF CLIENT: ____________________ **DATE :** __________

SIGNATURE OF PARENT, LEGAL GUARDIAN OR POWER OF ATTORNEY: ____________________ **DATE:** __________

WITNESS: ____________________**DATE:** __________

Signatures required: Adult client or patient (18 or over) and witness; if adult is adjudicated incompetent, then legal guardian or power of attorney (POA) and witness signature required; if child is 12 through 17; parent, legal guardian or power of attorney (POA) and child and witness signatures required; if child is under 12 years of age, parent, legal guardian or power of attorney (POA) and witness signatures required.
<u>**Authorization to release information and/or to limit disclosure and/or right to revoke consent may be abrogated by and/or superseded by court order and/or by applicable Federal and/or State law(s), including the Abused and Neglected Child Reporting Act and Illinois Department of Mental Health and Developmental Disabilities Mental Health Code and Confidentiality Act.**</u>

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