AMMIRATI COUNSELING
Empowering Your Relationships

2211B Lakeside Drive
Bannockburn, IL 60015

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Release of Information

Client Information

Name: _____ Date of Birth: _____

Home Address and Zip: _____

Phone: (Work) _____ (Home) _____ (Cell) _____

I authorize Ammirati Counseling and its associates to release information to and from:

Name: _____ Company: _____

Address and Zip: _____

Phone: _____ Fax: _____ Other: _____

Regarding any and all of the following information concerning my care.

This authorization expires on: _____/_____/_____

_____ In person (verbally)
_____ By phone (verbally)
_____ By written report — faxed, emailed, or mailed

Check all that apply:

_____ Any and all clinical information
_____ Intake/assessment
_____ Dates of treatment
_____ Progress notes
_____ Discharge summary
_____ Client status and progress report
_____ Other: _____

For the purpose of:

_____ Continuity of care
_____ Disability determination
_____ Evidence of care
_____ Aftercare services
_____ Reimbursement for treatment
_____ Other: _____

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences:

- Records in question will not be disclosed
- My insurance company will not be billed, and I will forego using insurance
- Other: _____

I understand that I may revoke this consent at any time by giving written notice, except to the extent that Ammirati Counseling has already taken action in reliance on it.

_____ _____
Client's signature (age 12 and older) Date

_____ _____
Parent/guardian of minor OR legally disabled recipient Date

_____ _____
Witness signature Date