Advanced Behavioral Centers of DuPage LLC
501 W. Ogden Ave, Suite 1
Hinsdale, Il 60521
Phone: (630)986-0599

For internal use only:

Check one:
___ Enter in chart only
___ Send Records
___ Obtain Records

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name:		Date of Birth:	i

I hereby authorize the Advanced Behavioral Centers of DuPage (ABC) to release and/or obtain the information concerning the above named client with:

Name of Person or Agency:			
Complete Mailing Address:		Phone Number:	

The information being released and/or requested will be used for the following purpose(s):

- ☐ Ongoing evaluation and treatment
- ☐ Coordination of services and supports
- ☐ Coordination of medical treatment
- ☐ Referral
- ☐ Academic planning and placement
- ☐ Personal file
- ☐ Litigation
- ☐ Insurance
- ☐ Other: _____

INFORMATION TO BE RELEASED	**INFORMATION TO BE OBTAINED** *For dates of service from: to:*
☐ Evaluation/Assessment	☐ Social & Family History
☐ Social History	☐ Health & Treatment History
☐ Diagnosis	☐ Evaluation Results
☐ Treatment or Service Plan	☐ Records of Contact
☐ Progress/Prognosis	☐ Discharge Summary
☐ Copy of Record	☐ Medication List
☐ Medication List	☐ Prognoses/ Treatment
☐ Discharge Summary	☐ Legal Status/Legal History
☐ Laboratory results (specify type & date:_____)	☐ Grades, Test Scores, Conduct, Attendance
☐ Billing Information	☐ Educational/Vocational Plans
☐ Other: _____	☐ Other: _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify date of expiration): _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the ABC. I understand that the person or agency receiving this information, in accordance with state regulations, will be notified not to disclose this information without further written consent. However, I understand that Advanced Behavioral Centers of DuPage cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosures of such information unless further disclosures are expressly permitted by written consent of the client or as otherwise permitted under federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting the ABC at the above address. I understand that ABC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW	**Type of Information**	**Authorizing**
I authorize the release of the information at the right, which requires specific consent:	Substance Abuse	☐ Yes ☐ No
Signature of Client/Legal Representative	Mental Health	☐ Yes ☐ No
Signature of Minor, if required:	HIV-related info	☐ Yes ☐ No

Signature of Client/Legal Representative _____ **Date:** _____

Relationship, if NOT the client: _____

Witness Signature _____ **Date:** _____

To the recipient of mental health information: Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in 410 ILCS 50. The unauthorized release of mental health information is unlawful, and civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Copy given to client Initials: _____