3140 W. Main Street
Saint Charles, IL 60175-1015
Office: (630) 216-9050
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www.stillwatershealth.com

Authorization to Release Information

Client Name_____Date of Birth_____Today's Date_____

Client Address_____Phone_____

_____

I,_____, authorize StillWaters Behavioral Health, LLC

to release the indicated information to _____.

I,_____, authorize_____

to release the indicated information to StillWaters Behavioral Health, LLC.

The following information may be released:

_____History/Physical Examination
_____Psychological Evaluation
_____Psychosocial History
_____Mental Health Assessment
_____Patient Treatment Records
_____Other_____

_____Psychiatric Evaluation
_____Legal Records
_____Diagnosis & Treatment Plan
_____Forensic Evaluation

This authorization is for the following purpose(s):_____Evaluation and Treatment Planning

_____Other_____

I understand that I have the right to inspect information I authorize to be disclosed, that it may contain drug and/or alcohol diagnoses and treatment information, and/or information related to mandated reporting obligations. I also understand that I have the right to revoke this authorization in writing at any time. If not revoked, this authorization is valid from the date of signature and will expire on_____.

I understand that my refusal to consent to release of the above information will prevent disclosure of the information. The consequences of my refusal, if any, are:

_____.

Client Signature (12 and over)_____Date_____
Parent or Guardian
Signature_____Date_____

Witness Signature_____Relationship_____