The Arlington Center
3375 North Arlington Heights Road/Suite F/Arlington Heights, Illinois 60004
(847) 577-4530 www.arlingtonctr.com

Release of Information Form

Client's Name: _____ Date of Birth: _____

Parent's Name (if different from client)**: _____**

I hereby authorize the release and/or exchange of confidential information (and hold harmless The Arlington Center, Ltd. regarding the use of information) related to myself/my family/case background from The Arlington Center and _____ (Therapist/Staff) to: _____

Information Released Includes:

- ❑ Psychological Evaluations (Testing)
- ❑ Treatment Summary/Summary Report
- ❑ Social, Medical, Family History
- ❑ Restricted Access or Other (specify):

_____

- ❑ Educational Records
- ❑ Diagnosis
- ❑ Billing Records
- ❑ Unrestricted Access to Any/All Files/Information

The information being released is for the purpose of continuity of care and treatment planning unless otherwise specified (Other Purpose, if Any: _____)

I am aware of my right to review information which is being disclosed:

X_____ X_____

Client (12 years old and over) **Parent/Guardian (if client is a minor)**

I have been told what consequence will occur if I refuse to sign: ____ YES ____ NO

X_____ X_____

Client **Parent**

I am aware of my right to revoke this consent at any time– however revoking does not affect past action:

X_____ X_____

Client **Parent**

A PHOTOCOPY OF THIS RELEASE FORM IS AS AUTHENTIC AS THE ORIGINAL SIGNED STATEMENT OF RELEASE.

NOTICE TO RECEIVING AGENCY/PERSON: *Please by advised that you may not disclose any of this information unless the person who consented to the disclosure specifically consents to such re-disclosure.*