MARVELOUS MINDS
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Authorization to Release Protected Health Information

I, (name)_____ hereby authorize Marvelous Minds to release information regarding (client)_____ to (Name/Phone)_____ (Address)_____

The following items must be checked & initialed to be included in the information released.

- ❑ _____mental health information
- ❑ _____ psychotherapy notes
- ❑ _____ sexually transmitted diseases
- ❑ _____ drug/alcohol information
- ❑ _____ HIV/AIDS related information

This release is for the following purpose(s): (check all that apply)

- ❑ _____ continuity of care
- ❑ _____ billing/payment/financial arrangements
- ❑ _____ consultation, advice, and representation regarding client's condition and needs

This consent is valid until (calendar date)_____.

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it with without my written authorization. I also understand if I refuse to consent the following may occur _____.

_____ _____ _____

Signature of adult client | Signature of client ages 12-17 | Date

_____

Signature of witness

NOTICE TO CLIENT & RECEIVING AGENCY: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION: The undersigned hereby revokes the above authorization.

_____ _____ _____

Signature of adult client | Signature of client ages 12-17 | Date

_____

Signature of witness