Center for Conscious Counseling

Dr. Ralph Whetstine, Psy.D. & Associates, P.C.
Fax: (708) 515-4471

Regarding: _________________________ DOB: ____________________

I, __________________________, have been informed of my rights concerning the release of confidential information and give my permission for

☐ Dr. Ralph Whetstine, Psy.D.
830 E. Higgins Rd, Suite 104H
Schaumburg, IL 60173
(708) 825-6108

☐ Dawn Whetstine, LCSW
850 E. Higgins Rd, Suite 125P
Schaumburg, IL 60173
(708) 825 6037

AND

Name: ____
Address: ____
Phone: ____

☐ To release/exchange information in verbal or written form OR
☐ Only to release information in verbal or written form

For the treatment period from: _________________ to _________________

Regarding the following information:

☐ Diagnosis and Assessment
☐ Progress Notes
☐ Summary of Treatment Participation/Progress
☐ Psychological Eval/Testing
☐ Recommendation/Consultation
☐ Medical History/Social History
☐ Medication
☐ Prognosis
☐ Discharge Summary
☐ Academic Performance
☐ Social Skills and Behaviors at School
☐ Emergency Contact
☐ Payment of Service
Other: ___________________________
____

For the purpose of
☐ Assisting with this individual's evaluation and treatment
☐ Continuity of care
☐ Other ______________________________________
☐ Coordination of care
☐ Payment of services by a third party

SPECIFIC AUTHORIZATION FOR RELEASE OF ADDITIONALLY PROTECTED INFORMATION

I understand that the information may include, when applicable, information relating to sexually transmitted diseases, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by CFR Part 1). I specifically authorize the release of data and information relating to: (Client, parent or guardian must initial item to be released)

______ HIV/AIDS related information and/or records

______ Mental health information and/or records

______ Drug/Alcohol diagnosis, treatment or referral information (Describe info to be disclosed)

I understand that:

- This information is not to be exchanged with any other agency/institution/or individual without my signed consent.
- I may withdraw this authorization at any time.
- My refusal to consent may hamper or prevent Dr. Ralph Whetstine or his associates' ability to provide services in the following way: ☒ unable to follow through with purpose (as selected above) and/or __________________________
____
- I have a right to inspect and copy the information to be disclosed to Dr. Ralph Whetstine or his associates prior to disclosure.
- Permission is valid until the stated date for a period of time appropriate for typical service information and correspondence needs and no long than one year: ______________________________________
(End of Consent Date)
note: if no end of consent is entered the release is valid only for the single day that it is signed)

IMPORTANT: Client, Parent or Guardian please initial that you have read this first of two pages ____________

And, I understand that Dr. Ralph Whetstine and Associates cannot guarantee the recipient receiving the requested health information will not re-disclose any or all of it to others. If the person or entity receiving the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

SIGNATURE(S) OF CLIENT, PARENT OR GUARDIAN:
(minor must sign if 12 or older)

Client Name (Please Print)	Signature of Client (age 12 or older)	Date
Parent/Guardian (Print)	Signature of Parent/guardian	Date
Witness (relationship)	Signature of Witness	Date

NOTICE: No person or company to whom any information is disclosed pursuant to this authorization may re-disclose such information unless the person who authorized this disclosure specifically consents to such disclosure.

NOTE TO RECEIVING AGENCY/PERSON: This information has been disclosed to you from records protected by Federal confidentiality rules under HIPAA (45 CFR, 160 & 164). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State law under the Mental Health & Developmental Disabilities Act (740 ILCS 110) regarding the confidentiality or mental health records also prohibits re-disclosure of this infuriation without the specific consent of the person who consented to the disclosure.

REVOCATION

As of this date, I hereby revoke the consent provided on this authorization form.

Name (Please Print)	Signature of Client or Parent/Guardian	Date
Witness (who can attest to the identity of the signatory)	Signature of Witness	Date

SPECIAL INSTRUCTIONS: The client must receive a copy of this document and the original must stay in the client records in accordance with state and federal laws.