

Southern IL Institute of Behavioral Health

Consent to Disclosure of Information and Records

I, _____ (Date of Birth: _____)
hereby authorize **Southern IL Institute of Behavioral Health** to release my records and reports relating to my appointments beginning with my first appointment on _____. This information is to be given to: _____; for the following purpose, use or need:

- Coordination of treatment
- Provision of information to other professionals
- Other _____

The following information from my records may be disclosed:

- General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- Psychotherapy Notes
- Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until six (6) months from date of signature.

Signature of Client

Date

Witness

Date

Consent By Person Other Than Client

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____ hereby certify that I am the _____
of the client; that the client is unable to consent because he/she is a
minor, _____ years of age or because: _____.

Signature of Parent, Guardian, etc.

Date

Witness

Date