

**Robert Silverman, M.S., C.R.C., L.C.P.C.**

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**AUTHORIZATION TO EXCHANGE INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
Street Address City, State Zip

Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (home) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (mobile / work)

**I hereby authorize Robert Silverman, M.S., C.R.C., L.C.P.C. to exchange the following information:**

- |                      |                           |                                 |
|----------------------|---------------------------|---------------------------------|
| Treatment assessment | Treatment recommendations | Medical & psychiatric records   |
| Diagnosis            | Treatment summary         | Family, home & background study |
| Treatment objectives | Chemical test results     | Fee payment history             |
| Treatment progress   | Relapses                  | Investigative reports           |

Other Information: \_\_\_\_\_

With: Name/Agency/Other: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City, State Zip

Telephone: (1) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (2) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PURPOSE OF DISCLOSURE: To Coordinate Services Other (specify) \_\_\_\_\_

Photocopy and facsimile of this authorization will be considered as valid as the original.

This authorization expires one year from today's date, or on this calendar date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ .

This authorization may be revoked by me at any time, except to the extent actions have been taken based on my signed release prior to the revocation request.

The consequences of refusing to sign this authorization are: no information will be released.

Client Signature (age 12 or older): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Revocation Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR Part 2). 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 use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.