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

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Champaign, Illinois 61820-7054
217-766-4327 *rob@robsilvermancounseling.com* *www.robsilvermancounseling.com*

- *Licensed Clinical Professional Counselor*
- *Certified Rehabilitation Counselor*

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.

In Illinois, clients 12 years of age and above are allowed to sign/decline release forms.

Use this side if multiple parties are being requested to release information.

I authorize the following parties/agencies to release/receive information contained in my records.

To/From Name & Address (circle)	***Client Date***	***Parent/Guardian Date***	***Witness Date***
To/From			
To/From			
To/From			
To/From			
To/From			
To/From			
To/From			
To/From			
To/From			
To/From			