Authorization for Release of Information

I (We) authorize Robin N. Heffernan, MS, LMFT, LCPC of Marriage and Family Solutions LLC at 290 Springfield Drive Suite 140 Bloomingdale, IL 60108

To release and disclose information from the clinical record of:

____ _______________

(Name of client/recipient of mental health services) (Date of birth)

To, and allow such information to be inspected and copied by:

____

(Facility/Provider)

____

(Address)

Nature of information to be disclosed:

____

(State specific nature of information to be disclosed)

For the purposes of:

____

(State specific purpose of information to be disclosed)

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Robin N. Heffernan, MS, LMFT, LCPC. I understand that a revocation is not valid to the extent that Robin N. Heffernan, MS, LMFT, LCPC has acted in reliance on such authorization. This authorization is valid until ________. (Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _______ no information released and/or____.

A copy of this release shall have the same force and effect as the original.

(Client Signature 12 yrs. or older) (Date)

(Parent/Guardian Signature) (Date)

(Witness) (Date)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.