Counseling for *Serenity*

Angela Rene Brown, LCSW ~ Counseling for Serenity ~ 815-600-1999
508 W Washington St., Yorkville, IL 60560 &
600 Spring Hill Ring Road, Suite 118, West Dundee, IL 60118

AUTHORIZATION FOR EXCHANGE OF INFORMATION

To maximize progress, it is beneficial to have coordination of treatment and to have healthcare providers and agencies working together. As such, I would like your permission to communicate with your physician, psychiatrist or other agency as named below.

I _____(hereinafter "client"), herby authorize
(name of client- and/or parent if client is a minor)
Angela Rene Brown, LCSW (hereinafter "provider") to exchange verbal and written information, mental health treatment information and records during the course of therapy with the client; including, but not limited to, providers diagnosis of the client and the clinical record with:

_____
(Name of facility or agency) (Name of doctor, provider, etc.)

_____
(Address)

_____
(Phone) (Fax)

I understand that have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by provider at 508 W Washington St., Yorkville, IL 60560 to be effective. 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.

This authorization is valid until _____.
(Date)

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) (Relationship)

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.