Labyrinth Counseling & Consulting Center, LLC

Authorization for Release of Mental Health, Alcohol, & Drug Abuse, and Other Personal Health Information

This form, when completed and signed, authorizes _____, my therapist at Labyrinth Counseling & Consulting Center, to release and/or exchange protected information from my clinical records to the person(s) or agency or agencies I designate.

I, _____, authorize my therapist at Labyrinth Counseling & Consulting
(Print full name here)
Center to release clinical session notes regarding treatment at Labyrinth Counseling & Consulting Center.

My clinical record or information is only to be exchanged with and released to:

1. _____

2. Compliance Medical Billing, Woodridge, IL (office) 630.541.7219, (fax) 815.346.5320, medbill06@gmail.com

3. _____

I am requesting Labyrinth Counseling & Consulting Center to release/exchange my clinical record or information for the following reasons ("At the request of the individual" is sufficient if you do not wish to state a specific purpose.)

[ ] At the request of the individual [ ] For therapist/counselor transition [ ] For billing, payment and related matters

[ ] For continuing treatment (mental health/ alcohol and/or drug abuse) or care, continuity of care

[ ] Other _____

This authorization shall remain in effect until _____ (usually one year from today's date). If no calendar date is stated, information may be released only on the date the authorization form is signed by you. You have the right to revoke this authorization, in writing, at any time by sending such a written notification to the above office address. However, your revocation will not be effective to the extent that Labyrinth Counseling & Consulting Center or my therapist has already released information based on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that if I refuse to consent to this release of my clinical record the following may occur:

[ ] insurance may not pay for services rendered [ ] insurance billing will not proceed through Compliance Medical Billing

[ ] lack of consistency and/or continuity of care [ ] _____

I understand that Labyrinth Counseling & Consulting Center, generally may not deny me counseling/psychotherapy services unless I sign an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health record at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such a re-disclosure. I further understand that if information is released to a party in another state, re-disclosure of information may be allowable according to their state law.

_____ _____ _____ _____
Signature of Client (age 12 or older) Date Signature of Witness Date

_____ _____
Signature of Parent/Guardian (if under age 18) Date

****

I hereby revoke this authorization. Signature _____ Date _____