Ann James
COUNSELING

Ann James Counseling, L.L.C.
1639 N. Alpine Road Suite 204
Rockford, IL 61107
(779)423-0275

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____
Date of Birth: ________________________

The undersigned hereby authorizes and requests: _______________________________________
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To release my records or exchange information with: Ann James Counseling, L.L.C.
1639 N. Alpine Rd. Suite 204
Rockford, IL 61107-1481

I understand that my medical records and/or information in connection with the hospitalization/treatment date(s) used for medical care may contain mental health, development disabilities, alcohol and drug use and/or Acquired Immune Deficiency (AIDS)/HIV test results which are privileged and confidential and may be disclosed only on my authorization, except as required by law.

I understand that this consent is revocable at any time prior to the release of this information. This authorization will expire 365 days from the date of my signature, unless I revoke it.

I agree to release and hold harmless the above named mental health provider from any and all liability, damages, claims or suits, including reasonable attorney's fees, in connection with the disclosure of records/information as authorized herein.

____ _____________________________
Patient Signature Date

____ _____________________________
Parent/Legal Guardian Signature Date

____ ______________________________
Witness Date