Collective Hope, LLC
1142 W. Madison Street
Suite 406
Chicago, IL 60607
(773) 599-9746

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize: Collective Hope, LLC; 1142 W. Madison Street, Suite 406, Chicago, IL 60607; 773-599-9746

to exchange information from records about _________________, born on ____________
(client name)

with:

Person or facility: _____________________________________

Address: _____________________________________ Phone: ______________

For the following purpose(s):

- ☐ Mental health evaluation, treatment, or care
- ☐ Treatment planning
- ☐ Other: ___________________________

These records concern the time between __________________ and __________________.

The information to be disclosed is marked by an X in the boxes below:

- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes, and treatment or closing summary
- ☐ Other: ____________________________________

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, in writing, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

______________________________	______________________________	___________________
Signature of client/parent	Printed name	Date

______________________________	______________________________	___________________
Signature of witness	Printed name	Date