Myers
Counseling
Group, Ltd.

300 Memorial drive, suite 200
Crystal Lake, Il 60014
Telephone: (815)308-3368
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CONFIDENTIAL STATEMENT OF RELEASE

I hereby authorize________________________________to release and/or exchange of
(Myers Counseling Group)

information with__________________________________(clinician) as initialed:
____
____
____

__ Initial work-up Psychological test reports Psychiatric evaluation

__ Summary of contacts Urinalysis test results Other _________________

For the purpose of: Facilitation of care_____________

I hold harmless_____________________\Myers Counseling Group, in regard to use of information authorized for release or exchange. This release expires 60 days after termination of services or at the discretion of the signed party. I have the right to cancel this release at any time, however, cancellation does not affect past action. I understand that I have the right to inspect and copy the information to be disclosed. It is understood that a refusal to authorize the release of the information specified above will prevent to disclosure of such information to the organization identified above, which may result in your not receiving the level of service you need.

Printed Name of Patient: ____

Social Security :_____________________________Birth date:_________________

Signed:___________________________________Date: _____________________

Signature of Parent or Guardian ____
(if 18 years of age or under)

Witness:________________________________Date:__________________

Notice to recipient: Under Illinois and Federal Confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure.

A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical records.