Myers Counseling Group, Ltd.

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CONFIDENTIAL STATEMENT OF RELEASE

I hereby authorize (name of therapist (check one) ☐ Mark Myers ☐ Janet Myers to release and/or exchange information with (Name of clinician or hospital) as initialed:

(Please fill out as much of the below as possible. Talk to your therapist if you still do not have all the contact information for the clinician/hospital.)

Name of clinician or hospital _____

Address of clinician or hospital _____

Telephone number of clinician or facility _____

Email address of clinician or facility _____

Check as many as indicated:

☐ Initial workup psychological reports ☐ Psychiatric evaluation ☐ Summary of contacts

☐ Urinalysis test results ☐ Other

For the purpose of facilitation of care, I hold Mark Myers Janet Myers (MCG therapist) harmless in regard to the use of information for release or exchange. This release expires 60 days after the 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 actions. I understand that I have the right to inspect and copy information to be disclosed. It is understood that a refusal to authorize the release of the information specified above will prevent the 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: _____ Birth date: _____

Signed: _____ Date: _____

Signature of Parent or Guardian: (If 18 years of age or under) _____

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 statement of release. An original will be retained in the medical records. Witness: