Authorization to Release Information

This form, when completed and signed by the patient or parent/guardian, authorizes the Hawthorn Counseling Group clinician indicated below to release protected health and mental health information to the person or organization designated

i authorize the following chilician with nawthorn	counseling Group, John D. Jochem, Psy.D. to release the
following information (Description of Information t	o be Disclosed: (Patient/Client should initial each item to be
disclosed)):	
Assessment	Toxicology Reports/Drug Screens
Diagnosis	Educational Information
Psychosocial Evaluation	Discharge/Transfer Summary
Psychological Evaluation	Continuing Care Plan
Psychiatric Evaluation	Progress in Treatment
Treatment Plan or Summary	Demographic Information
Current Treatment Update	Psychotherapy Notes
Medication Management Information	Verbal Communications Only
Presence/Participation in Treatment	Other:
Nursing/Medical Information	Billing Information
I am requesting this information be released for the	& address of person/organization to whom the information
information can be released only on the date on wh	/
Group).	

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Hawthorn Counseling Group. However, any such revocation will not be effective to the extent that Hawthorn Counseling Group has already taken action in reliance upon this authorization or if this consent was obtained in connection with processing of health insurance claims and the insurer has a legal right to contest a claim.

I understand that if I refuse to consent to this authorization, the consequences of my refusal, if any are as follows: my mental health records and/or communications will not be disclosed.

I understand that I have the right to inspect and copy the disclosed mental health records and communications at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure. However, I understand that Hawthorn Counseling Group has no control over the risks of redisclosure by the recipient of this authorization and agree to hold Hawthorn Counseling Group harmless for such a possibility.

Signature of Patient	Date	Parent/Guardian	Date
Witness	 Date		