Behavioral Medicine P.C.

Cynthia Kindgren MS/LCPC
Licensed Clinical Professional Counselor
Owner - Clinical Director

Tara White MSW/LCSW
Licensed Clinical Social Worker
Independent Contract Therapist

For Release and Exchange of Protected Health Information

Client Name:_____ DOB:_____ Phone #_____

Address: _____ City:_____ State:_____ Zip:_____

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person(s) you designate, and for Behavioral Medicine, PC to receive protected information from that person.

I authorize Behavioral Medicine PC to release:

___ Neuropsychological/Psychological/Neurofeedback Evaluation, Date: _____
___ Outpatient psychotherapy consultation notes, Date: _____
___ Other (describe and date):_____
_X_ Any and All

This information should only be released to and/or received from:

1. **Name: Referring Physician**_____
   Address_____
   Phone _____
   For the purpose of continuing care_____

2. **Name** _____
   Address_____
   Phone _____
   For the purpose of continuing care_____

3. **Name:**_____
   Address_____
   Phone _____
   For the purpose of continuing care_____

4. **Name:**_____
   Address_____
   Phone _____
   For the purpose of continuing care_____

This authorization will remain in effect until:_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address: however, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to consent a claim. I understand that mental health practitioners generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect disclosed mental health information 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.

Client signature/Legal Representative: _____Date: _____

The above information may be redisclosed by medical Pain Management Services for further medical care.
Client signature/Legal Representative: _____Date: _____

If the authorization is signed by a legal representative of the client, a description of such representative's authority to act for the client must be provided:_____

Witness Signature:_____Date:_____