

Studio For Change®

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Consent to Release/Request Client Records/Information

To: _____

Phone: _____

Client: _____

DOB: _____

- _____ Educational Records
- _____ Health/Medical Records
- _____ Psychiatric Evaluations
- _____ Psychological/Neurological Assessments & Diagnosis
- _____ Therapy Notes
- _____ Treatment Evaluation
- _____ Other:
- _____ Any and all records/information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release _____ (treating therapist) from any and all liability arising from release and disclosure of the information and records. I/We understand that I/We have the right to inspect and copy the information to be disclosed. I/We understand that I/We may refuse to consent to disclosure prior to the information being sent.

I/We have read the above and have had the opportunity to ask questions concerning this consent. Including the consequences, if any, of refusal to consent. This consent is valid for one year from the date it is signed. This release expires on ___/___/___.

Client Signature
(age 12 and over must sign)

Date

Parent / Guardian

Witnessed by: _____
Therapist Signature