F.A.I.R.
COUNSELING

Consent for Release of Information

I, _____
(Name of Patient) (Birth Date)

_____
(Address)

Authorize Families and Adolescents in Recovery (FAIR), Inc.
2010 E. Algonquin Road, Suite 207
Schaumburg, IL 60173

By checking the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Medical History & Physical
- ☐ Bio-psycho-social Assessment
- ☐ Lab/Toxicology Reports
- ☐ Psychological Consultations _____
- ☐ Psychological/Neuropsychological Testing
- ☐ Chemical Dependency Evaluation/Consultations
- ☐ Progress Reports
- ☐ Educational Reports
- ☐ Alcohol & Drug History
- ☐ Other (Specify) _____

☐ **All Information**

To be sent to/received from: _____
(Name)

_____
(Address and Phone)

For the purpose of: _____

Information released is not to be further disclosed or used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me, and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior to then. I understand I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility or person named herein for the stated purpose. I also understand that refusal to consent to the release of information specified above may result in further consequences, such as:

- ☐ Failure to coordinate services/collaborate treatment
- ☐ Inability to provide treatment services

This Authorization is valid until (one year from current date) _____
(Calendar Date)

Patient Signature _____ Date _____

Parent Signature _____ Date _____

Witness Signature _____ Date _____

Signatures Required: Adult patient (18 or older) and witness; Parent (or guardian) and child plus witness, if child is 12 to 17; Parent (or guardian) and witness, if child is under 12 or patient is adjudicated incompetent.