Authorization for Release of Confidential Information

Patient Name: ____ Date of Birth: _____________________

I authorize: **SASHA VON VARGA, LCSW &** COLLABORATORS, INC.
466 Central Avenue Suite #27
Northfield, IL 60093
Phone/FAX: 847-446-7924

To: ☑ **release to** **and/or** ☑ **receive from**

____
NAME OF AGENCY OR PRACTITIONER

____
STREET ADDRESS

____
CITY, STATE, ZIP

____
TELEPHONE # **EMAIL**

the following confidential information:

- ☑ Confirmation of application for services
- ☑ Mental Health report of intake, assessment, diagnosis, and/or service recommendations
- ☑ Mental Health report of treatment and/or interventions
- ❑ Closing or discharge summary
- ❑ Substance Abuse assessments, reports, evaluations, and treatment summaries
- ☑ Other (Specify): ____

For the Purpose(s) of: ❑ Legal ❑ Continuing of Care ❑ Personal ❑ Other______________

For the following period of Time__________________________________

(If treatment period is unspecified, only records from past 6 months will be released)

This consent is valid until: ____ .
(DATE MUST BE FILLED-IN AND MAY NOT EXCEED ONE YEAR FROM DATE OF SIGNATURE)

I understand that I may revoke this consent at any time by giving written notice to Sasha von Varga, LCSW and that I have the right to inspect and copy the information disclosed. It has been explained to me that if I refuse to consent of release of information, services may be delayed or denied.

Signature of Patient ____ Date ____________________
(MUST SIGN IF 12 YEARS OF AGE OR OLDER)

Signature of responsible party ____ Date ____________________
(MUST SIGN IF PATIENT IS UNDER 18 YEARS OLD)

Relationship of responsible party to patient____

Signature of Witness ____ **Date** ______________________

NOTICE TO RECEIVING AGENCY OR PERSON: Information disclosed to you from records whose confidentiality is protected by federal or Illinois Laws and regulations may not be disclosed by you without consent for re-disclosure by the client and/or parent or legal guardian.