Jill Scott-Trainer, MSW, LCSW
4300 Commerce Court Suite 300-10
Lisle, IL 60532-3698
630.699.5279
www.jsttherapy.com

I, _____, whose Date of Birth is _____/_____/_____,

Authorize Jill Scott-Trainer, MSW, LCSW to disclose to and/or obtain from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax:_____

the following information:

Description of Information to be Disclosed

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify: _____
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Jill Scott-Trainer, MSW, LCSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:_____
If a calendar date is not stated, information may only be released on the date the authorization is received.

Conditions
I further understand that Jill Scott-Trainer, MSW, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.). I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____
Signature of Client /Date

_____
Signature of Parent, Guardian or Personal Representative/Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____
Signature of Staff Witness Attesting to Identity & Authority/ Date