Release of Information to Your Insurance Company

I hereby give permission to **Centers for Family Change** to release _____ (initial) my treatment record and information regarding my treatment.
Client name: _____, DOB _____,

To *(fill in name of your insurance company)*

_____

Disclosure of the Entire Treatment Record (including information about treatment planning, progress and recommendations) for the purpose of obtaining authorization for continued treatment is given to Centers for Family Change.

Right to revoke: I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I also understand that Centers for Family Change or any of its employees cannot be held liable for any disclosures authorized by this release that occurred prior to the date of revocation.

I understand that unless revoked by written notice, this authorization for release of information is valid and binding for course of my treatment with the Centers for Family Change.

Signature of client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of others (those 12 or over who attended sessions): _____

_____ Date: _____

Witnessed by: _____ Date: _____

Notice regarding redisclosure: The Illinois Mental Health and Developmental Disabilities Confidentiality Act, stipulates that communications and records may be redisclosed only if the person(s) who authorized this disclosure specifically authorize such redisclosure.
Notice of responsibility: The Centers for Family Change is not responsible or liable for others use of disclosed/released information.

Centers for Family Change 2625 Butterfield Road, Suite 101 N., Oakbrook, Il 60523

phone: 630 586-0900 fax: 630 586-9990