Padilla Counseling, LTD.
125 Windsor Drive, Suite 113 Oak Brook, IL. 60523 (708) 435-9224

Kristy V. Padilla
Licensed Clinical Professional Counselor

Consent to Release Confidential Information

1. I, _____, am requesting the release of my protected health information.
(print your name)

2. I authorize Padilla Counseling, Ltd. to disclose information regarding my psychological treatment to the person or organization listed below. Padilla Counseling, Ltd. is authorized to:
   1.) Receive information from this party or parties and
   2.) Provide information to this party or parties.

3. I authorize Padilla Counseling, Ltd. to disclose the above noted information to this person and/or organization:
   Name of Person or Organization: _____
   Phone Number: _____
   Full Mailing Address: _____

4. The information will be used/disclosed for the following purposes:
   ___ Treatment Planning ___ At the request if the parent or legal guardian ___ Referral
   ___ Continuity of care Other: _____

5. I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here: _____I understand that after this date or event, no more of this information can be used or released to the person or organization unless I sign a new form.

6. I understand that I can revoke or cancel this authorization at any time through a written and signed request. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been disclosed before that date.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, that Kristy Padilla, LCPC, cannot guarantee the ongoing privacy of the disclosed information.

9. I understand and agree that there may be administrative charges associated with the use or disclosure of my health information. The relevant financial arrangement has been explained to me and I understand and accept it.

10. I affirm that everything in this form that was not clear to me has been explained.

I, named client, agree to all of the above.

_____ _____
Signature of client or his/her personal representative Date

**If signed by someone other than client, please indicate the relationship between client and his/her representative:*
_____

Signature below indicates that the clinician has discussed the issues above with the client and/or the client's personal representative. My observations give me no reason to believe that this person is not fully competent to give informed/willing consent.

_____ _____ _____
Signature of professional Printed name of professional Date