Coping Partners™

ChildrenCoping™ Clinic

155 Revere Drive, Unit 8 • Northbrook, Illinois 60062 • copingpartners.com

CHILD
or Disabled Adult

CLIENT LAST NAME: _____

I hereby authorize: _____

_____

_____

_____

To use, release, and exchange mental health and medical information and records obtained during the course of treatment of:

Client Name (Print): _____ Date of Birth: _____

Approximate Date(s) of Service: _____ Client No. _____ (if available)

1. The information is to be disclosed/exchanged with the following:

Coping Partners/Children Coping Clinic
155 Revere Drive, Unit 8
Northbrook, Illinois 60062
copingpartners.com

SEND RECORDS TO THE ATTENTION OF:

_____

PHONE: _____

E-MAIL: _____

2. Purpose: The purpose of the use or disclosure is for:

☐ Treatment Planning
☐ Other _____

3. Persons Authorized and information to be used or disclosed:

The information to be used or disclosed by Coping Partners/ Children Coping Clinic, its independent contractors, psychologists, social workers, providers and other employees includes only those items checked below. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. The information to be used or released includes:

☐ Psychological Testing
☐ History and Physical Exam
☐ Consultation Reports
☐ Education – Clinical Progress
☐ Education – IEP/School Assessments
☐ Education – School Assignments
☐ Medication Records
☐ Verbal Communication – No Restrictions
☐ Verbal Communication Restrictions
  ☐ Limited to Checked Areas Above
  ☐ Restrictions – Specific Individuals

☐ Discharge Summary
☐ Integrated Assessments
☐ Psychiatric Evaluation
☐ Physician Orders
☐ Physician Progress Notes
☐ Therapist/Social Services Progress Notes
☐ Treatment Plans
☐ Clinical Aftercare Plan
☐ Laboratory Data
☐ Other: _____
_____
_____

This authorization is limited to only that information requested above to be disclosed to or by Coping Partners/Children Coping Clinic. I/we hereby release the Coping Partners/Children Coping Clinic from all legal responsibilities or liability that may arise from the use, disclosure or redisclosure of medical or other records and other health information in reliance on this authorization.

PLEASE SEE REVERSE →

CHILD
or Disabled Adult

CLIENT LAST NAME:_____

Mandated Recitals:

1. **Expiration: I/we understand that unless I revoke the authorization earlier, this authorization will automatically expire on _____.**

2. **Redisclosure:** I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party.

3. **Refusal to sign:** I/we understand that I/we may refuse to sign this authorization and the result would be that the records would not be disclosed.

4. **Certification:** The undersigned affirms that I am (check whichever applies):
   - ☐ The client, and the identification that I have provided is true and correct.
   - ☐ The client's authorized representative, and that the identification and proof of authority that I/we have provided are true and correct. My relationship to the client is that of:
     ☐ Parent ☐ Guardian ☐ Other _____

5. **Revocation:** I/we have the right to stop the use or release of this information at any time if I do so in writing to Coping Partners/Children Coping Clinic although I/we understand that I/we cannot do anything about information already used or disclosed pursuant to this authorization.

6. **Copy Received:** I/we understand that I/we will receive a copy of this completed form.

7. **Inspect and Copy:** I/we understand that I/we have the right to inspect and copy the information to be disclosed.

8. **Challenge:** I/we understand that I/we have the right to challenge the accuracy of any information contained in the subject file.

9. **Effect of Copies:** I/we intend that fax, copies or electronic versions of this document shall carry the same force and effect as the original.

10. **Alcohol/Substance Abuse Files:**
    If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient.

_____ _____
DATE **CLIENT SIGNATURE - AGE 12 OR OVER**

_____ _____ _____
DATE **WITNESS TO CLIENT SIGNATURE** **PRINTED NAME**

_____ _____ _____
DATE **PERSONAL REPRESENTATIVE SIGNATURE** **PRINTED NAME**
(PARENT, GUARDIAN OR OTHER AUTHORIZED AGENT)

_____ _____ _____
DATE **WITNESS TO PERSONAL REPRESENTATIVE SIGNATURE** **PRINTED NAME**