THE FAMILY INSTITUTE
at Northwestern University

CONSENT FOR RELEASE OF INFORMATION
THE FAMILY INSTITUTE

Client Name _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

The undersigned authorizes The Family Institute (TFI) to: [Circle the option(s) that is(are) appropriate] release to obtain from

Name _____ Relationship _____

Address _____ Phone Number _____

the following records and information concerning client, for the period of _____(m/d/y) to _____(m/d/y).
Initial the category(ies) of information that is (are) appropriate.

_____ Discharge Summary _____ Treatment Notes _____ Treatment Plans

_____ Social Assessment _____ Psychiatric Evaluation _____ Correspondence

_____ Psychological Evaluation _____ Telephone Consultation _____ Progress Reports

_____ HIV related information (client must sign this separately) _____

_____ Drug and Alcohol use, evaluation or treatment information (client must sign this separately) _____

_____ Other (specify): _____

I also authorize re-disclosure of records from the following individuals and/or agencies: _____

This information shall be used for the following purpose (s):

_____ follow-up care _____ placement _____ treatment planning _____ other (specify) _____

_____

This consent expires on _____. If no date is specified, the consent shall be valid only on the date received for this particular consent for release of information. I understand that I may revoke this consent in writing at any time but that such revocation is effective only with respect to any future requests for disclosure and does not retroactively apply to any disclosure made by _____ in reliance on this release prior to the date it receives a revocation from me. I also understand that any written revocation must be accompanied by the signature of a witness.

I understand that the consequence of my refusal to consent, if any, would be: _____

Date _____ Signature of client (required if client is 12 years of age or older) _____

Date _____ Signature of parent or guardian (required if client is under 18 years of age or has been adjudicated incompetent) _____

Date _____ Witness _____

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, no person or agency to whom any of this information is disclosed may re-disclose such information unless the person who consented to this disclosure specifically consents to such re-disclosures.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.

Effective August 1, 2005, The Family Institute requires a copying fee for anyone requesting records (i.e., patients, attorneys, insurance carrier) in the amount of $20 for up to 20 pages of material, plus an additional $0.10 per page beyond 20. Waivers of this fee will be considered upon written request to the medical records department.