Upswing Counseling

620 W. Roosevelt Rd. Ste C-2
Wheaton, IL 60187
Office: 630-480-4118 Fax: 847-807-3080

Consent for Release of Information

I, _____
(Name of Patient) **(Date of Birth)**

_____,
(Address)

authorize Upswing Counseling to release and/or receive information regarding:

☐ permission to discuss my case

☐ copies of materials in my file: ☐ notes ☐ test results

☐ Other: _____

Release to/Receive from:

Name: _____

Address: _____

Phone # _____

This information is to be used for the following purposes:

_____

This authorization is valid for one year from date of signing and limited to only that information.

* _____
(Patient's Signature) **(Date)**

* _____
(Parent's or Guardian's Signature) **(Date)**

* _____
(Witness' Signature) **(Date)**

***Signatures required:** Adult patient (18 or over) and witness: Parent (or guardian) and child plus witness, if child is 12 through 17; Parent (or guardian) and witness, if child is under 12 or patient adjudicated incompetent.*