#### Sharon Rukin, PhD, LCPC

Licensed Clinical Professional Counselor

Authorization for Release of Information

I HEREBY AUTHORIZE:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

TO RELEASE TO: Sharon Rukin, Ph.D., LCPC

And/or 7101 N. Cicero Avenue,, Suite 203

RECEIVE FROM: Lincolnwood, IL 60712

The following information: Therapy history, diagnostic impressions, treatment goals, response to treatment, medication history, current medications, psychosocial history, current functioning, and other relevant clinical information regarding:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Full Name (please print) Birthdate

1. In signing this form, I understand the following provisions:
2. I am under no obligation to sign.
3. I have the right to inspect and copy any written information that is exchanged.
4. This release will remain valid for one year.
5. I have the right to revoke this authorization at any time by written request (except for information already exchanged).
6. Opting not to sign will mean that information will not be requested or released.
7. The purpose of the release is for:
	1. Continuity of care and treatment planning
	2. Third party reimbursement
	3. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (minor 12 – 17 years of age)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_