

ANXIETY & AGORAPHOBIA TREATMENT CENTER, LTD.

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(847) 559-0001

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FAX (847) 559-8438

CONFIDENTIAL

Regarding: _____

Birth date: _____ S.S. # _____

STATEMENT OF RELEASE

I hereby authorize the release and / or exchange of information as initialed:

_____ initial assessment

_____ summary of contacts

_____ psychiatric examination

_____ other _____

_____ restrictions _____

FROM: _____ TO: _____

FROM: _____ TO: _____

FOR THE PURPOSE OF: _____

I hold harmless the Anxiety & Agoraphobia Treatment Center in regard to the use of information authorized for release or exchange. This release expires on _____, or at the discretion of the signed party. I have the right to cancel this release at any time. However, cancellation does not affect past action.

SIGNED: _____ DATE: _____

SIGNATURE OF PARENT OR GUARDIAN: _____

WITNESS: _____ DATE: _____

Notice to recipient: Under Wisconsin and Illinois and Federal Confidentiality Provisions, you may not re-disclose any of the information provided without specific authorization for such re-disclosure.

A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical records.