

**CONSENT FOR RELEASE OF INFORMATION**  
Mental Health Centers of Central Illinois

Site Contact Info on Reverse

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> The Children's Center | <input type="checkbox"/> Logan-Mason Rehabilitation Center | <input type="checkbox"/> MHCCI-Jacksonville |
| <input type="checkbox"/> MHCCI-Lincoln         | <input type="checkbox"/> Memorial Counseling Associates    | <input type="checkbox"/> MHCCI-Springfield  |

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Client ID#:** \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the mutual sharing of my highly confidential information between Mental Health Centers of Central Illinois and the following individual agency or individual:

\_\_\_\_\_  
Name of agency or individual and address/phone # (if applicable)

**TYPES OF INFORMATION TO BE RELEASED (client/guardian must initial information to be shared)**

Client	Guardian	Type of Information	Date Range of Information to Release
		<b>Medical</b> (includes results of past medical assessment, treatment, treatment results, recommendations)	
		<b>HIV Testing or Treatment</b> (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)	
		<b>Psychiatric/Psychological</b> (including diagnosis, assessments, treatment plans, current and/or past treatment progress, medication history, recommendations)	
		<b>Alcohol/Drug</b> (including diagnosis, assessments, treatment plans, current and/or past treatment progress, medication history, recommendations)	
		<b>Educational</b> (including attendance, conduct, expulsions, special education assessment, social history, individual educational plans, progress in meeting educational goals, educational recommendations)	
		<b>Child Welfare</b> (including incidents resulting in DCFS involvement, comprehensive assessments, service plans, progress on service plans, placement history, court reports, recommendations)	
		<b>Legal</b> (including arrests, convictions, probation history, progress on probation/parole, detentions history, recommendations)	
		<b>Other:</b>	

**PURPOSE FOR RELEASE OF INFORMATION (client/guardian must initial information to be shared)**

Client	Guardian	Purpose for Requesting Information
		Coordination of services with the above agency or individual
		Consultation with the above individual or agency for continuity of care and/or treatment planning
		Transfer of treatment
		Other:

- Method Information Will be Released:** (only checkmark is required)
- |                                       |                                  |  |
|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Verbally     | <input type="checkbox"/> Written | <input type="checkbox"/> Photocopy/Written |
| <input type="checkbox"/> Audio        | <input type="checkbox"/> Video   | <input type="checkbox"/> Fax               |
| <input type="checkbox"/> Other: _____ |                                  |  |

**Client/Guardian must initial to confirm understanding**

	I understand that a copy or fax of this consent will be considered legal in lieu of the original document.
	I understand that I have the right to inspect and copy the information to be disclosed and that this highly confidential information will not be re-disclosed without proper authorization.
	I understand that my refusal to consent to the release of the above-mentioned information will prevent disclosure of the information.
	I understand this consent is valid for one (1) year following this date, and may be revoked in writing at any time except to the extent that action has already been taken.

\_\_\_\_\_  
Client Signature (if over age 12)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

MHCCI CONTACT INFORMATION

**The Children's Center**  
 5220 S. 6th Street Road  
 Suite 2400  
 Springfield, IL 62703-5761  
 Office: 217/757-7700  
 Fax: 217/757-7799

**Logan-Mason Rehabilitation Center**  
 760 S. Postville Drive  
 Lincoln, IL 62656  
 Office: 217/735-1413  
 Fax: 217/735-5780

**MHCCI-Jacksonville**  
 340 W. State Street  
 PO Box 370  
 Jacksonville, IL 62651  
 Office: 217/245-6126  
 Fax: 217/245-4296

**MHCCI-Lincoln**  
 304 8<sup>th</sup> Street  
 Lincoln, IL 62656  
 Office: 217/735-2272  
 Fax: 217/732-9847

**Memorial Counseling Associates**  
 901 N. 1<sup>st</sup> Street  
 Springfield, IL 62702  
 Office: 217/788-4065  
 Fax: 217/788-4147

**MHCCI-Springfield**  
 710 N. 8<sup>th</sup> Street  
 Springfield, IL 62702  
 Office: 217/525-1064  
 Fax: 217/525-9047

**OFFICE USE ONLY**

**Information Released**

**Date Released**

**Staff Initials**

Comprehensive Assessment(s)

\_\_\_\_\_

\_\_\_\_\_

Psychiatric Evaluation(s)

\_\_\_\_\_

\_\_\_\_\_

Treatment Plan(s)

\_\_\_\_\_

\_\_\_\_\_

Progress Note(s)

\_\_\_\_\_

\_\_\_\_\_

Other (specify):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_