

# LODESTONE

CENTER FOR BEHAVIORAL HEALTH

15 Spinning Wheel Rd  
Suite 426  
Hinsdale, IL 60521  
P. 630.323.3050  
F. 630.323.3058

1011 Lake St  
Suite 421  
Oak Park, IL 60301  
P. 630.323.3050

3923 Mercy Dr  
Suite F  
McHenry, IL 60050  
P. 815.344.5061

111 Dean St  
Woodstock, IL 60098  
P. 815.344.5061  
F. 815.344.5072

645 N Michigan Ave  
Suite 1005  
Chicago, IL 60611  
P. 815.344.5061

## Request/Authorization to Release Confidential Records and Information

I hereby authorize:

**The LodeStone Center for Behavioral Health** to release information from records about:

\_\_\_\_\_ ,  
(name of client)

\_\_\_\_\_  
(date of birth)

for the following purpose(s)

- Further mental health evaluation, treatment, or care
- Rehabilitation program development or services
- Treatment planning
- Research
- Other: \_\_\_\_\_

### Receiving Party:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

These records include time between the dates of \_\_\_\_\_ and \_\_\_\_\_.

Only the information with an X through the box below will be released:

- Intake and discharge summaries
- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records
- Psychological Evaluations
- Progress notes, and treatment or closing summary
- Other: \_\_\_\_\_

I have a right to inspect a copy of any and all materials that will be disclosed.

Should I refuse to disclose, the consequence could be:

\_\_\_\_\_

\_\_\_\_\_

**Select One:**

- Please forward the records to The LodeStone Center at the Woodstock address at the top of the front of this form.  
 Please forward The LodeStone Center records to the address written under "Receiving Party."

**I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except in the event that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.**

\_\_\_\_\_

Printed name of patient

\_\_\_\_\_

Signature of patient

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_

Date

**I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent but was physically unable to provide a signature.**

\_\_\_\_\_

Signature of witness

Date

Copy for patient or parent/guardian  Copy for source of records  Copy for recipient of records