Wellman Psychology & Associates, S.C.
Licensed Clinical Psychologists
Assessment, Psychotherapy, and Consultation
3660 N. Lake Shore Drive, Suite 201
Chicago, IL 60613
(773) 683-1731

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________ D.O.B______________, do hereby authorize
(Name of Client--Recipient of mental health services) **&** **(Date of Birth**)
Wellman Psychology & Associates, S.C. to release AND exchange information from the clinical record regarding my protected health information to:

____
(Write name of person, health care provider, facility, or etc.)

____
(Address)

____
(Phone)

For the purposes of (Please check all that apply)

Treatment and Follow-up: __________ Psychological Evaluation: ______________

Coordination of Care: _____________ Other (specified): _____________________

Information to be released and exchanged includes the following:
(Please check all that apply for VERBAL and WRITTEN **Release** and **Exchange**)

(1) VERBAL RELEASE AND EXCHANGE
Social _____ Medical _____ Psychological _____

(2) WRITTEN RELEASE AND EXCHANGE
Social _____ Medical _____ Psychological _____

Valid from_____________________ to ____________________
(Today's date) (Usually one year later)

I understand that have the right to rescind this authorization at any time by sending WRITTEN notice to Wellman Psychology & Associates at 3660 N. LAKE SHORE DRIVE, SUITE 210 Chicago IL 60613. I understand that a withdrawal of this release is not valid to the extent that Dr. James D. Wellman has acted in confidence on such authorization.

Signature: __________________________________ Date: __________
(12 YEARS OR OLDER)
Parent/Guardian: ____________________________ Date: __________

Witness: ____________________________________ Date: __________