**The Chicago Stress Relief Center, Ltd.**

**1440 Techny Road**

**Northbrook, IL 60062**

**Phone: (847)412-0756**

**Fax: (847)412-0756**

[**drhweissman@aol.com**](mailto:drhweissman@aol.com)

[**www.stressreliefcenter.com**](http://www.stressreliefcenter.com)

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

I authorize The Chicago Stress Relief Center, Inc. and/or Howard K. Weissman, Psy. D. to release clinical and/or assessment information about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the purpose of clinical impressions, treatment planning, discharge and/or aftercare.

The consent is valid until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (one year after today’s date).

**I understand I may revoke this consent at any time and that I have the right to inspect and copy the information disclosed**.

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**Client’s Signature** **Date**

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**Witness Signature** **Date**

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

Under the Federal Act of July 1, 1975, Confidentiality and Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may further disclosed without specific authorization for such disclosure.

(Adopted from)

Illinois Mental Health and Development Disabilities

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