

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name

I, _____, hereby give permission to:

1. _____, to disclose to Sierra Counseling & Mediation, LLC and its representatives; and /or
2. Sierra Counseling & Mediation, LLC and its representatives to disclose to:

The information to be released includes:

- _____ evaluation and /or continued treatment
- _____ information to determine leave of absence from work or disability benefits
- _____ copies of all medical records on file
- _____ periodic updates regarding treatment plan
- _____ other (Please, explain.)

This consent is valid for the twelve-month period following the date of signature unless otherwise indicated on the following line:

The consent is valid until: _____

I understand that this authorization may be revoked at any time by informing the facility releasing the information. **Revocation must be in writing.**

Client - print name

Signature

Date

Guardian - print name

Signature

Date

SIERRA COUNSELING & MEDIATION, LLC
2900 Frank Scott Parkway, Suite 986, Belleville, IL 62223
P: 618.233.9355 F: 618.233.9357 E: www.viviansierra.com

Witness – print name

Signature

Date

The information to be disclosed is protected by the Illinois Mental Health and Developmental Confidentiality Act or the Federal Confidentiality of Alcohol and Drug Abuse Patient Act.

The specific nature of the information to be disclosed is:

- Mental Health Treatment Records,
- Alcoholism Treatment Records,
- Substance Abuse Treatment Records
- and/or HIV/AIDS.

The purpose of the disclosure is:

- evaluation,
- continued treatment,
- treatment planning,
- and/or work release/disability benefits/EAP benefits.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences:

Information will not be disclosed, except as provided by law.

I understand that the person receiving this information has the right to inspect and copy the information disclosed.

I understand that Vivian Sierra, Ph.D. may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by given written notice to the provider of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the provider has already relied on it to use or disclose my health information. Written revocation must be sent to the provider's office.

Signed: _____ Date: _____

Witness: _____ Date: _____

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

Under the Federal Act of July 7, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, no information from such records may be further disclosed.