Hope Enrichment Center, P.C.
Professional Clinical Counseling Services
7300 W. College Dr, Suite 203, Palos Heights, IL 60463
708-448-7848 • 708-448-7845 (fax)
www.hopeenrichmentcenter.com

Release for Disclosure of Confidential Records and Information

Re: Records of_____ **Treatment Dates**_____

I,_____,date of birth,_____ authorize the release of copies, or allow inspection of, mental health records for the above named individual.

○ **From**	_____
○ **To**	*Hope Enrichment Center, P.C.*
○ **Between**	*7300 W College Dr., Suite 203*
	Palos Heights, IL 60463

○ **From**	_____
○ **To**	_____
○ **Between**	_____
	_____
	Phone_____
	Fax_____

The information and/or records to be disclosed include:

- ○ Mental Health Evaluations
- ○ Diagnosis
- ○ Treatment Plan
- ○ Summary of Treatment to Date
- ○ Progress Notes/Treatment Records
- ○ Conversation between above parties to discuss case
- ○ Intake & Discharge Summaries
- ○ Complete Medical Chart
- ○ Lab Reports
- ○ Psychosocial & Developmental History
- ○ Billing Records
- ○ Other: _____

This information is being released for the purpose of:

- ○ Quality of care
- ○ Treatment Planning
- ○ Other:_____
- ○ Clinical/Diagnostic Evaluation
- ○ Report Preparation

Consequences of refusal to consent: _____

Expiration of Consent: This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this consent will expire on _____, 20_____.

Right to Revoke: This release is voluntary on my part. I may take back this consent at any time, except to the extent that action based on this consent have already been taken.

Authorization: I hereby authorize the information described above to be released.

_____	_____	_____
Signature of patient	Printed name of patient	Date
_____	_____	_____
Signature of Witness	Printed name of Witness	Date

Hope Enrichment Center, P.C. reserves the right to charge for requests for medical records. My signature acknowledges this processing fee.
Process fee for medical records: $24.44
Per page fee: $ 0.92 (pages1-25)
$ 0. 61 (pages 26-50)
$ 0.31 (pages 51+)

☐ Copy for patient ☐ Copy for *Hope Enrichment Center, P.C.* ☐ Copy for recipient