JULIE LEARNER, LCSW
Performance Coach & Sports Therapist

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Northbrook, IL 60062
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize Julie Learner, LCSW, to disclose and/or obtain from _____the following information:

_____Assessment
_____Diagnosis
_____Psych Eval
_____Treatment Plan
_____Current Update
_____Participation in trtmt

_____ Medical info
_____ Toxicology Report
_____Drug Screens
_____Progress in trtmt
_____Medication Info
_____Other_____

Purpose
The purpose of disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, specify_____

Revocation
I understand that I have the right to revoke this authorization at any time by sending written notification to Julie Learner, LCSW, at 900 Skokie Blvd., suite 116, Northbrook, IL 60062. I further understand that a revocation is not effective to the to the extent that action has been taken in reliance on this authorization prior to its revocation.

Expiration
Unless sooner revoked, this consent becomes effective _____ and expires_____.

Form of Disclosure
Unless I have specially requested in writing that the disclosure be made in a certain format, Julie Learner, LCSW, reserves the right to disclose information as permitted by the authorization in any matter deemed appropriate and consistent with appropriate law, including electronic.

Conditions
I further understand that Julie Learner, LCSW, will not condition my treatment on whether I give full authorization for the requested disclosure. I understand that I have the right to inspect and copy the information to be disclosed. I further understand that a refusal to authorize the release of information specified above will prevent disclosure of such information to the organization/person identified above, which may result in your not receiving the level of treatment you need.

Signature of Client **Date**

Signature of Parent, Guardian, or Personal Representative **Date**