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*One who knows others is wise. One who knows self is enlightened.*  
Tao Te Ching

### Request/Authorization to Release Confidential Records and Information

I hereby authorize: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ to release / obtain (circle or cross out) information about \_\_\_\_\_, birthdate: \_\_\_\_\_ for the following purpose(s):

\_\_\_\_ Mental health evaluation, treatment or care    \_\_\_\_ Treatment planning    \_\_\_\_ Consultation

\_\_\_\_ Other: \_\_\_\_\_

Services were delivered from (approximate dates): \_\_\_\_\_ to \_\_\_\_\_ .

The information to be disclosed / obtained (circle or cross out):

\_\_\_\_ Intake and discharge summaries    \_\_\_\_ Social History    \_\_\_\_ Psychiatric evaluation

\_\_\_\_ Psychological evaluation(s)    \_\_\_\_ Treatment summary    \_\_\_\_ Educational records

\_\_\_\_ Other: \_\_\_\_\_

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: \_\_\_\_ Do not release this information.

The consequence of not releasing the above information is: \_\_\_\_\_

I have had explained to me and fully understand this request/authorization to release / obtain records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any except to the extent that action based on this consent has already been taken. This consent will expire automatically on \_\_\_\_\_, after the purpose described above has been fulfilled, or 6 months from the date on which it is signed, whichever comes first.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian of client

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian of client

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_ Copy accepted by client    \_\_\_\_ Copy kept by therapist    \_\_\_\_ Original sent to source/recipient of records

*This is a strictly confidential patient medical record. Redislosure or transfer without express written consent is expressly prohibited by law.*