Walking Together Therapy Associates, P.C.

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I, ___________________________, D.O.B. __________,

Hereby Authorize: ___Andrea F. Benn, Ph.D., M.Ed., ___Sandra M. Corbett, L.C.P.C., ___Scott M. Cyphers, L.C.P.C., ___Carole A. Dankers, L.C.P.C., ___Patrick J. Kennelly, Ph.D., ___Ray S. Kim, Ph.D., ___Antoinette M. Krakowski, Psy.D., ___Robert A. Lasica, L.C.S.W., C.C.T.P., ___Maria E. Matusiewicz, MA, L.C.P.C., ___Terry Neary, Ph.D., C.A.D.C., ___Pei-Shan Yu, Ed.S., L.C.P.C.: To release any and all records to and/or to obtain information from:

Name:

Address:

Phone Number: Fax Number:

Specific nature of information to be disclosed:

__HIV/AIDS related treatment
__Mental health information
__Psychotherapy notes
__Assessment/Diagnosis
__Drug/alcohol diagnosis, treatment/referral
__Treatment Recommendations
__Treatment Plan
__Progress Reports on my treatment
__Psychological Testing
__My Entire Record
__Sexually transmitted diseases
__Other (specify):

For the purpose of: (please check all that apply)

__ Continuity (health and mental health) treatment of care and continuity of care
__ Therapist transition
__ Housing and other arrangements or services
__ Billing, payment and financial matters and arrangements
__ Case management (including certification determinations)
__ Processing of a benefit claim
__ Consultation, advise and representation regarding my condition and needs
__ Other (specify):____

This consent is valid until **(calendar date)** ___________________________

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time, by submitting a written and dated notice of revocation. Any such revocation will not affect materials disclosed prior to the revocation. I also understand that Patrick J. Kennelly, Ph.D. & Associates, P.C. or any of its employees therefore cannot be held liable for any disclosures prior to the date of such revocation. The above named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization.

______________________ ______________________ ______________________

(Minor recipient, 12-17yrs. Inclusive) (Signature of adult patient or parent) (Date)

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provision of the Illinois Mental Health and Development Disabilities Confidentiality Act, HIPPA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for Psychotherapy notes.