Rebecca Dwyer-Elias, LCSW, LISW
Dwyer-Elias Counseling and Therapy, P.C.
1800 3rd Avenue, Suite 516 Rock Island, Illinois 61201
#309-788-1050

Consent and Authorization for Disclosure of Information

I, ____ Date of Birth______________

Street Address____

City____ State__________________ Zip________________

Authorize: Rebecca Dwyer-Elias, LCSW, LISW, 1800 3rd Avenue, Suite 516, Rock Island, IL. 61201

To: **Disclose to**___________ **Request From**____________ **Exchange With**______________

Name____

Address____

The Following Information:

________Confirmation of Contact
________All Records
________Psychiatric Evaluation
________Discharge Summary
________Summary of Care
________Psychological Evaluation
________School Records
________ History & Physical
________Other (Specify) ____

For the Purpose of ____

Covering the period from____________________to______________________.

I understand that:

I may request to inspect the information to be disclosed.

I make revoke this consent and authorization at any time. This would stop further disclosures, but would not affect any previous disclosures.

The Consent and Authorization shall expire automatically on__________________________.

Signed____ Date______________________
(Patient or authorized person)

Signed____ Date______________________
(Minor's signature if 12-17 years)

Signed____ Date______________________
(Witness)