Sonja Glad, MA, DPsS, LCPC

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Springfield, IL 62704
Phone (217) 720-5981

Authorization to Release Information

To/From: Sonja Glad MA, NCC, LCPC

To/From: _____
Name Phone

_____
Address City State Zip code

RE: _____
Full name of client Date of Birth

The specific type of information to be disclosed is as listed below:

____Complete record
____School Progress Reports
____Initial Evaluation
____Discharge Summary
____Medication Record
____Oral Communication Only

This information will be used for the purpose of evaluation, treatment and continuity of care (or) _____

This may even include information regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases. Further, I understand that refusal to consent to release of information will result in records not being released. If you do not wish certain information to be released, state type of information to be excluded_____

I understand that this consent is revocable at any time PRIOR to the release of information. This authorization will expire ONE YEAR from the date below. I understand that I retain the right to inspect and copy the information to be disclosed upon written request. I hereby release you and your personnel from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____
Signature of client or legal representative Date

_____ _____
Witness Date