Chantelle L. Taylor-Bittings LCPC
Merrionette Park,IL 60803

Authorization for Release of Information

RE: ____ _________________________________
(Patient's Name) (Date of Birth)

____
(Street Address) (City) (State) (Zip Code)

I hereby authorize Chantelle L. Taylor-Bittings, Chicago, IL 60620 708-297-1037 to release and obtain

____ oral ____ written information

to/from:
____
(Name of physician, agency, facility or person)

____
(Street Address) (City) (State) (Zip Code)

____
(Phone Number)

Concerning the above named client for the purposes of:

____

____with regard to mental health treatment.

Information to be released includes:

____ Evaluation/psychological testing ____ Treatment Plan

____ Treatment Summary ____ Complete Record

____ Other: ____

I understand that I have the right to inspect and copy any written information to be disclosed and that I have the right to revoke this consent at any time by giving written notice to Chantelle L. Taylor-Bittings, LCPC.

This release is valid from ______________ to ________________ (one year maximum).

____ ____________________
Client Signature Date

____ ____________________
Chantelle L. Taylor-Bittings, LCPC Date