

# **Release of Information**

Jeanne Dickerson M.A., L.C.P.C., C.P.C.C. • Downers Grove, IL • (630) 986-8310  
Licensed Clinical Professional Counselor and Certified Professional Co-active Coach

I \_\_\_\_\_, hereby give consent to  
\_\_\_\_\_ to release information to \_\_\_\_\_  
regarding services provided for \_\_\_\_\_.

**Provider's Name and Address:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Provider's Name and Address:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Nature of Information to be Disclosed:**

- Statement of when counseling sessions occurred
- Phone consultation with other provider regarding treatment issues and goals
- Counseling notes
- Records from other providers
- Other \_\_\_\_\_

This consent is valid for one year from the date that it is signed, therefore it expires on \_\_\_\_\_.  
I understand that I have a right to inspect and copy the information to be disclosed and that I may  
revoke this consent at any time by notifying Jeanne Dickerson in writing.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality  
Act, this confidential information may not be further disclosed, released, or shared with other  
parties.

**Signature**  
\_\_\_\_\_  
\_\_\_\_\_  
(if recipient of services is a minor,  
state your relationship to the minor)

**Witness**  
\_\_\_\_\_  
\_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_