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A Rejuvenated Mind Behavioral Health, PLLC

50 N. Brockway St, Suite 4-1. Palatine, IL 60067 Phone:
224-877-1730

General Release of Information

I authorize A Rejuvenated Mind Behavioral Health, PLLC to:

Disclose ☐ Obtain ☐ Disclose and Obtain ☐

The following information:

☐ Psychosocial Evaluation ☐ Assessments ☐ Treatment Plan
☐ Behavioral Plans ☐ Progress Notes ☐ Presenting Problem

From the following entity:
Name of Individual/Organization: _____

Address: _____

Phone: _____ Fax: _____

Regarding the following individual:
Legal Name: _____ Date of Birth _____

For the Purpose of: _____

It is my understanding that information will be disclosed by mail, email, verbal, or by fax. The following are restrictions, if any _____

This authorization is valid from _____ to _____

It is my full understanding that the records and communications to be disclosed will include sensitive information. Examples of this information are evaluations, treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs.

I understand that I have the right to review, as well as obtain a copy, of the information to be disclosed prior to its disclosure.

It is my understanding that I may revoke this consent at any time. I understand that revocation must be presented to A Rejuvenated Mind Behavioral Health, LLC in writing. The revocation of this consent is not effective until a formal letter is received.

Should you choose to decline to sign this form, the consequence will be no communication with the identified entity.

Signature of Individual (age 12 or older): Date: _____

Signature of Parent/Guardian (if under 18 or has a legal guardian) Date: _____

Witness: Date: _____