GunderKline Counseling LLC
Eve GunderKline, LCSW
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(872) 216-6623
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Client Consent to Release Information

Client name:____

Date of Birth:_______________________

I hereby authorize and request Eve GunderKline, to release to, obtain from, and discuss the following with:

Person/agency:____

Address:____

Telephone number:____

This information will be used for the purposes of evaluation and planning and is confined to the following specified information:

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, no person or agency to which any of this information is released may disclose the information unless redisclosure in specifically consented. I understand that I may revoke this consent at any time, but not retroactive to the prior release of information made in good faith. I understand that if I decide to revoke this authorization that such revocation must be in writing and signed, dated, and witnessed. Additionally, I understand that I have the right to inspect and copy information disclosed.

This authorization is valid until_______________. If date is not specified, this authorization is valid until one year from the date signed.

Signature of client:______________________________________ Date:_____________

Signature of therapist:___________________________________ Date:______________