Quantum Counseling

6912 Main Street, Suite 123
Downers Grove, IL 605126

Authorization for Disclosure of Information

I, ____, authorize

Quantum Counseling Inc. and it's representatives to release or exchange information concerning me from/to, _Kareo medical billing;____

____

Information to be release or exchanged may include:

_x___Psycho-social History
_x___Treatment Plan
____Educational/vocational history
_x___Treatment Progress
_x___Substance use history
_x___Psychiatric evaluation
_x___Diagnosis
__x___Discharge summary
__x___Treatment recommendations
______Diagnostic Testing
_____Health History
_____Physical/lab exam results
___x__Mental status
___x___Attendance

For the purpose of:

____Completing Evaluation
_x___Submission for Billing/Insurance
______Coordination of Services
______Other

If not withdrawn, this authorization expires on ____________________.

I understand that I may withdraw this authorization in writing at any time and that failure to sign may result in the inability to provide services.

______________________________________ __________________

Signature of Client Date

______________________________________ __________________

Signature of Parent/Guardian Date

______________________________________ __________________

Signature of witness Date