Quantum Counseling Inc.
6912 Main Street, Suite 123
Downers Grove, IL 60516

COORDINATION OF TREAMENT

It is important that all health care providers work together. Therefore, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s) **____I decline to inform my physician**

I, ____, authorize Quantum Counseling and its representatives to release or exchange information concerning me (or my child) from/to:

PHYSICIAN NAME: ____

CLINIC: ____

ADDRESS: ____

PHONE: ____

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:

__X__ Completing Evaluation
__X__ Submission for Billing/Insurance
__X__ Coordination of Services
_____ Other

If not withdrawn, this authorization expires on ____________________.

Client Signature(s) ____ Date ____________

Parent/Guardian Signature(s)_______________________________________ Date ____________

Witness Signature ____ Date ____________