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

Authorization for Disclosure of Information

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

Kareo Medical Billing & Compliance 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:

__X__ Completing Evaluation
__X__ Submission for Billing/Insurance
__X__ 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If not withdrawn, this authorization expires on ____________________.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.

____ _______________

Client Signature(s) Date

____ _______________

Parent/Guardian Signature(s) Date

____ _______________

Witness Signature Date