Michelle Kukla, Psy.D.
800 East Northwest Highway, Suite 500, Palatine, IL 60074
Phone: (847) 701 – 4452 Fax: (847) 907 - 9994

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____ - _____ - _____

Street Address: _____ Age: _____

City, State, Zip: _____ Phone Number: _____

I hereby authorize _____Dr. Michelle Kukla_____ **and**
(Clinical Psychologist)

Name: _____ _____
(Person's name we are exchanging information with) (Person's relationship to you)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

to *(circle one or both)* **release / receive** information contained in my client records for dates ❑ all treatment dates **or**
❑ specific dates which include from _____ to _____, as identified and checked below:

❑ Medical History ❑ Psychological Testing

❑ Chemical Dependency Evaluation/TX ❑ Progress Notes / Mental Health Treatment

❑ All information pertaining to the psychological treatment and/or evaluation of this client

The purpose and need for disclosure: ❑ for the purpose of assisting in the evaluation and treatment of this client **or**

_____

I understand the following provisions:

a) I am under no obligation to sign.

b) I have the right to revoke this authorization at any time by written request.

c) This consent is valid for six months (180 days), or until the following specific date, event , or condition:

❑ specific expiration date: _____ ❑ specific event:_____

❑ treatment relationship is terminated

_____ Print Client's Name	_____ Signature of Client (age 12 and older)	_____ Date
_____ Print Parent/Guardian's Name	_____ Signature of Responsible Party (if different than client)	_____ Date
_____Michelle Kukla, Psy.D._____ Clinician's Name/Witness	_____ Signature	_____ Date