EVALUATION CENTER FOR LEARNING
Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441-4433

CONSENT FOR RELEASE OF INFORMATION

Date: _____

Patient's Name_____ Date of Birth _____

I hereby authorize the Evaluation Center for Learning (ECFL) to (please check one)

_____ Release/Disclose ONLY (ECFL may provide information to the person/organization stated below)

_____ Gather and Use ONLY (ECFL may collect and use information from the person/organization stated below)

_____ Exchange (ECFL may share information, i.e., provide and collect information, from the person/organization stated below)

individually identifiable information to/from/with: _____

Address: _____

Phone Number: _____ Email Address _____

Description of the information: _____

_____

Approximate dates of treatment: _____

I understand that my decision to sign this form and authorize this use and/or disclosure of information about me, as described above, is entirely voluntary and I may refuse to sign this form. I have the right to inspect and copy the information to be disclosed. If I do not sign this form, the information will not be disclosed other than by court order or as requested by law. I understand that I may revoke this consent in writing at any time. Any such revocation will have no effect on disclosures made prior to the date the revocation is received

This consent is valid for one year from date OR until _____ (date).

Signature:

_____ _____
Patient or Recipient of Service (if over 12 years old) Date

_____ _____
Parent or Legal Guardian (if under 18 years old) Date