SANKOFA
PSYCHOLOGICAL SERVICES

8 S. Michigan Ave
Suite 2100, Chicago, IL 60603
312-344-1081

Request/Authorization to Release Confidential Records and Information

Client Name: _____ DOB: _____
Address: _____ Ph: _____
SS/ID Number: _____

I authorize the release of information and communication between the following parties:

Release to / from :	Release to / from: _____
Sankofa Psychological Services	Name: _____
8 S. Michigan Ave., Suite 2100	Address: _____
Chicago, IL 60603	City/State/Zip: _____
Ph: 312-344-1081	Ph: _____
Fax: 312-488-4624	Fax: _____

The purpose of this communication and release of information is:
[ ] Further mental health evaluation, treatment, or care
[ ] Treatment planning [ ] Research [ ] Other: _____

These records concern the time between _____ and _____ inclusively.

The information to be disclosed is marked by an X in the boxes below.

[ ] Intake and discharge summaries	[ ] Medical history and evaluation(s)	[ ] Mental health evaluations
[ ] Developmental and/or social history	[ ] Educational records	[ ] Psychological Evaluations
[ ] Alcohol/Chemical use	[ ] Progress notes, and treatment or closing summary	
[ ] Other: _____		

I have a right to inspect a copy of any and all materials that will be disclosed. Should I refuse to disclose, the consequence could be incomplete diagnostic evaluation, recommendations, or treatment. Additional consequences of refusal to consent may be:
_____

Select:
[ ] Please forward the records to Sankofa Psychological Services at the address on the top of this form.
[ ] Please forward the Sankofa Psychological Services records to the address written above.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action, based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Client's Signature	Client's Printed Name	Date
_____	_____	_____
Sankofa Staff Signature	Sankofa Staff Printed Name	Date
_____	_____	_____
Parent/Guardian (if applicable)	Parent/Guardian (if applicable)	Date