Solid Foundations Therapy, Inc

5201 Washington St, suite 2, Downers Grove, IL 60515 *(847) 644-9043*

Release of Information

I, _____ hereby authorize the therapists and staff of ***Solid Foundations Therapy, Inc*** and their designees to exchange information with:

_____

Name of facility or person

_____

Address City, State, Zip

_____

Phone

For the purposes of:

____Assessment
____Coordination of Treatment
____Medication management
____Gathering relevant information to treat client
____Other

I understand that I may revoke this consent at any time without penalty. I understand that signing this form allows the designees of ***Solid Foundations Therapy, Inc*** to exchange my personal and medical information with the above-listed person or entity.

Signed: _____ _____
Client *Date*

_____ _____
Parent/Guardian (if applicable) *Date*

_____ _____
Witness *Date*