Alison Toback, LCPC
708 Church Street, Evanston, Illinois 60201
alison@alisontoback.com
773-209-2440

AUTHORIZATION for RELEASE OF INFORMATION:

I hereby give my permission for Alison Toback, LCPC to contact or be contacted by the party listed below to discuss information related to my treatment. I understand that the information divulged will be to facilitate treatment, that I can withdraw this authorization at any time, and that the contact with this party will be treated in accordance with professional ethics and Illinois laws. I am aware that I have a right to inspect any written documents released and make photocopies of them if I desire. Further, I am aware that I can revoke this authorization at any time prior to the end of the authorization period specified below by providing written notice to Alison Toback, LCPC.

Name of Client: _____

Date of Birth: _____

Party to be contacted: _____

Nature of information to be released: _____

_____

Purpose of information released: _____

_____

_____

_____

Signature of Client: _____

Print name of Client: _____

Date: _____

Expiration date: _____