

# Authorization for Release of Information

**REV. J. LYNN JAMES, LCPC**  
Ordained Minister  
Licensed Mental Health Counselor

I, \_\_\_\_\_, authorize Lynn James, LCPC, to  
*(please your print name)*  
release/request information regarding \_\_\_\_\_  
*(specific nature of information to be disclosed)*  
to \_\_\_\_\_ for the purpose of facilitating  
*(agency/person)*  
and coordinating services and \_\_\_\_\_.  
*(if there are other purposes)*  
This consent is valid through \_\_\_\_\_.  
*(month / day / year)*

I understand that I can revoke this consent at any time.

It has been explained to me that the following are the consequences of my refusal to consent to this release/request of information:

Signature \_\_\_\_\_ Date \_\_\_\_\_

If under 18 years of age, the parent/guardian signature:

\_\_\_\_\_ Date \_\_\_\_\_

## Note to receiving agency/person:

*Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure consents to such re-disclosure.*

## QUESTIONS?

If you have any questions or concerns about any of this information, please don't hesitate to talk to me.

**Rev. J. Lynn James, LCPC**

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