



CONSENT TO RELEASE INFORMATION

NAME/CLIENT: _____

By executing this form, I consent to the release of information between NAMI DuPage and the individual listed below and/or agency.

Entity from whom information is received:

Name: _____ Telephone: _____

Address: _____ Email: _____

Information to be Received:

Name and contact information of referred client or individual. _____

Purpose of Release:

To allow NAMI DuPage staff and/or Peer Counselor get in contact with client for referred services.

This consent takes effect from the date of signature. It automatically terminates as follows:

After one (1) year (for provision of ongoing services). Date of termination: _____

Other (if client agrees to extend beyond one year). Date of termination: _____

I understand that I can withdraw my consent to the release of the information specified herein at any time by providing NAMI DuPage with written notification.

Client

Date