Heartlinks Grief Center
Research/Educational Authorization for Release of Client Information Form

Client/Guardian Name

Children(s) names (if relevant)

Please read the statements below and initial your understanding of each statement.

I understand that I am under no obligation to sign this form and that the Heartlinks Grief Center may not condition treatment or payment on my decision to sign this authorization.

Client/Guardian Initials

I understand that Heartlinks will be receiving direct and/or indirect remuneration in connection with the use and/or disclosure of health information from the Madison, St. Clair County Mental Health Board, and other granting institutions. Information from case files may also be used confidentially or anonymously for billing, research/educational, supervisory purposes. Information may include demographic and case file documentation.

Client/Guardian Initials

I have received and read a copy of the HIPPA form. Heartlinks staff has explained to me and I understand the confidentiality constraints and rules that apply to all of Heartlink's counseling and referral services.

Client/Guardian Initials

I understand that I have the right to revoke this authorization in writing. I am aware that my revocation will not be effective if Heartlinks staff and organizational personnel have already acted in reliance upon this authorization.

Client/Guardian Initials

I understand all of the information presented in this form and authorize Heartlinks Grief Center to release my information as outlined above. By signing this form, I indicate my agreement to allow Heartlinks staff and volunteers to provide services.

Please sign and date to indicate your understanding of this authorization form.

Client or Guardian Signature **Date**

Heartlinks Signature **Date**