

Counseling Associates, Inc.

33045 Hamilton Court
Suite W-300
Farmington Hills, MI 48334
Phone (248) 848-1558

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

I, _____, hereby authorize COUNSELING ASSOCIATES, INC.,
(Patient Name)

of Southfield, Michigan, its Director or Designee, to release and/or obtain information contained in my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any, and social services records, if any, including communications made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

Birthdate of Patient _____ Social Security Number _____

1. Name of Individual(s) or organization(s) to/from whom disclosure is to be made: _____

Address: _____

2. Specific type of information to be disclosed: * _____

3. The form in which the information may be disclosed is (check one or more options): by verbal communication _____
by written report or photocopies of records _____ or other (explain) _____

4. The purpose and need for such disclosure: (For mental health records, include a statement as to how the information to be disclosed is pertinent to the purpose and need for such disclosure.) _____

5. This consent is subject to revocation at any time except in those circumstances in which the Clinic has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given with respect to alcohol and/or drug abuse records shall have a duration of no longer than that reasonably necessary to achieve the purpose for which it is given.

6. Without expressed revocation, this consent expires on the date set forth below or for the following specified reasons:
CONDITION: Once information is disclosed. No further information can be disclosed pursuant to this consent.
or Date: _____ or Event: _____ or None: _____

Signature of Patient

Date

Signature of Parent, Guardian or Representative

Date

Signature of Witness

Date

*Limit information only to those areas necessary if entire case file is not necessary.

THERE MAY BE UP TO A \$25.00 FEE FOR RECORD COPY