Center for Family Psychiatry

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Saline, MI 48176

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Name: _____ DOB: _____
Address/City, State/Zip/Phone Number:_____

I, _____, hereby authorize the Center for Family Psychiatry to release and exchange information contained in my clinical record to/from:

Name of person(s) or organization(s): _____

Address/City, State/Zip/Phone Number:_____

Specific information to be disclosed (check all that apply):

- ☐ Discharge Summary
- ☐ Psychosocial History/Evaluation
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing Information
- ☐ Identifying Information
- ☐ Treatment Plan
- ☐ Medical Progress Notes
- ☐ Psychotherapy Notes
- ☐ Lab Reports
- ☐ Physical Exam
- ☐ Diagnosis
- ☐ Financial Information
- ☐ Substance Abuse Related Information
- ☐ HIV/AIDS Related Information

The purpose and need for such disclosure (check all that apply):

- ☐ Provision of Services
- ☐ Coordination of Care
- ☐ Evaluation/Assessment
- ☐ Continuation of Services
- ☐ Medication Review
- ☐ Aftercare Planning
- ☐ Billing/Payment Purposes
- ☐ Eligibility Determination
- ☐ Other_____

I understand that authorizing this request to disclose information in my records is voluntary. I understand that any release/disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by Federal Confidentiality Laws.

This authorization, except for action already taken, may be revoked at any time by verbal or written notice to the Center for Family Psychiatry. Without expressed revocation this authorization expires after one year, or sooner for any one or more of the following reasons:
I. Date: _____ II. Event: _____ III. Condition: _____

Patient/Client Signature	Date
Legal Guardian, if client is a minor	Date
Witness Signature	Date

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Laws which prohibit you from making any further disclosure of this information without the specific consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the request/disclosure of medical or other information is NOT sufficient for this purpose.
Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.