RELEASE OF INFORMATION

Authorization for disclosure of mental health treatment information

Patient Name: _____ DOB: _____ Phone: _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION BETWEEN BOTH PARTIES INDICATED BELOW:

FROM:

_____
(Provider Name)

Alternative Perspective Counseling, LLC
4295 Okemos Rd., Suite 135
Okemos, MI 48864
Phone: 517.331.9380
Fax: 517.331.9381

TO:

_____
(Name/Organization)

_____
Address

_____
City, State, Zip

_____
Phone

_____
Fax

Description of information to be disclosed:
Initial those that apply; will be disclosed upon request.

_____ Treatment Updates
_____ Psychotherapy Notes
_____ Medical Records
_____ Treatment Summary
_____ Discharge Summary
_____ All of the above
_____ Diagnosis
_____ Treatment Plan

Purpose: Coordination of care with mental health provider.

Conditions: This consent may be cancelled at any time to the extent that the health care provider named above or custodian of the records has not already taken action in the reliance upon it. This authorization will automatically expire 1 year from the date it is signed. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by the authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically. There is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations. This information is disclosed in accordance with the Federal confidentiality rules (42 CFR, Part 2), Section 748 of Michigan Public Act 258, 1974 and Michigan Public Act 174, 1989.

I hereby release the person or organization sending these records and results from liability associated with interpreting, evaluating, or reporting the results. I have read the above and acknowledge that I understand the terms and conditions of this authorization.

_____ _____
Signature of patient Date

_____ _____
Signature of parent/guardian Printed Name

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