The Center for Counseling
Your Life Is Precious.℠
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047-1985
Phone: 586.273.7095 Fax: 586.273.7196

Request/Authorization for Release of Information

I, ____, ____________________ hereby authorize the staff of
(Client's Name) DOB
The Center for Counseling to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to who disclosure is to be made:

   ____ Attention: ____

   ____ Approximate dates of service at site from which information is

   ____ requested: ____

2. Information to be disclosed:

   ❒ Diagnosis ❒ Drug/Alcohol History ❒ Treatment Summary

   ❒ Attendance ❒ Mental Status Exam ❒ School Records, specify: ____________________

   ❒ Progress ❒ Physical Examination ❒ Entire Record: ____________________

   ❒ Prognosis ❒ Discharge Summary ❒ Other ____________________

3. Purpose of disclosure:

   ❒ Provision of Mental Health Services ❒ Billing Purposes ❒ Aftercare Planning

   ❒ Continuity of Treatment ❒ Family Involvement ❒ P.O./Attorney/Judge/Court

4. Without expressed revocation, this consent expires 90 days after discharged from treatment.

5. This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

____ ____________________
Client (Parent/Guardian) Signature Date

____ ____________________
Staff Signature Date