

Oakland Psychological Clinic, P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(PRINT)

CONFIDENTIAL

Form with fields: Patient Name, Birth Date, S.S. #, Other Names Used in Treatment

I authorize the disclosure of records about me (or my minor child) between:

Form with fields: Name, Address, City, State, Zip, Attention, Phone, Fax

and

Form with fields: Relationship, Name, Address, City, State, Zip, Attention, Phone, Fax

Information may include any of the following:

Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Initial all that apply to person/organization listed above.)

The authorizing person must place his/her initials next to the type of information to be disclosed:

Grid of information types with checkboxes: Appointment Information, Assessment, Dates and/or Completion of Tx, Discharge Summary, Financial/Insurance Information, Identifying Information, Lab Results, Physical Examination, Progress Notes, Progress Report, Psychiatric Med. Reviews, Other: Specify, Psychiatric Evaluation, Psychological Testing, Thank You Letter, Treatment Plans, Urine Drug Screens

Purpose and need for such disclosure: (Initial all that apply to person/organization listed above.)

The authorizing person must place his/her initials next to the purpose for the disclosure:

Grid of disclosure purposes with checkboxes: After Care Planning, Assessment of Patient, Continuity of Care, Disability Benefits, Driver's License Appeal, Educ. Planning/Placement, Employer Req./Job Stability, Emergency Contact, Family Involvement, Insurance Benefits, Legal Services/Compliance, Payment, Pre-Employment Screening, Referral for Services, Social Security Benefits, Treatment Planning, Workers Comp. Benefits, Other: Specify

Revocation of authorization: This Authorization may be revoked by me at any time by my written notice to the above named individual or organization, except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.

Without expressed revocation, this consent expires for the following reason(s), whichever is later (check one box):

- Checkboxes for: Date: (One year from discharge unless otherwise specified), Event, Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

Redisclosure: While Oakland Psychological Clinic, P.C. does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.

Form with fields: Patient Signature, Parent/Legal Guardian Representative, Witnessed by, Date

This patient declined communication with their Primary Care Physician and the "Importance of Coordination of Care with Your PCP" was given to him/her.