Counseling Associates, Inc.

6960 Orchard Lake Road
Suite 100
West Bloomfield, MI 48322
Phone (248) 626-1500

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

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

of West Bloomfield, Michigan, its Director of 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

12/04