Authorization for Release and Disclosure and/or Request for Medical Information and Records

Client Name: _____ (patient) Date of Birth: _____
authorizes Lakeview Counseling, PC to (check one or both below or form is invalid):

☐ Release information from my medical records to the individual/organization listed below

☐ Request information from the individual/organization below

Name: _____
Address: _____

For the following purposes, use or need: _____

_____

_____

The following information from my psychiatric/medical records may be disclosed, covering the dates from: _____ to _____

☐ Initial Assessment ☐ Discharge Summary ☐ Psychiatric Evaluation

☐ Treatment Summary ☐ Psychological Treatment ☐ Physical Exam

☐ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

☐ Other: _____

☐ Exclude the following information: _____

I acknowledge such information cannot be disclosed without informed consent unless otherwise provided by law. I farther understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse. and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of I 996 (HIPAA) protects the privacy of the health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749, and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations. Part II, with which this authorization complies. The released information may not be copied, shared or re-released. except as consistent with the authorized purposes stated above.

I understand that I am not required to sign this authorization, and Lakeview Counseling, PC will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

I have had the opportunity to have this form explained to me and have my questions answered.

Patient/Parent/Guardian/ Personal Representative Signature	Date	Witness Signature	Date

Copy of this authorization provided: ☐ Yes ☐ Declined

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378