

# Aric Cohen, LMSW, CSW, PLC

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## CLIENT/PATIENT INFORMATION RELEASE AUTHORIZATION

DATE: \_\_\_\_\_

CLIENT/ PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I \_\_\_\_\_, hereby Authorize \_\_\_\_\_ to release information contained in my client/patient records, as required and specified by HIPAA (45-CFR) standards, and including alcohol and drug abuse records protected under the Regulations in 42 Code of Federal Regulations, Part II, (42-CFR); information concerning human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC), if any, protected under Michigan Public Act 174 of 1989, as amended; psychological services records and social services records, if any; and psychiatric records, if any, to the individuals or organizations and only under the conditions listed below:

1. Name or title of person or organization and address to whom the Disclosure is to be made or designee: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Specific type of information (including dates of treatment) to be disclosed:  
Diagnosis \_\_\_\_\_; Attendance \_\_\_\_\_; Prognosis \_\_\_\_\_; Discharge- Summary \_\_\_\_\_;  
Recommendations \_\_\_\_\_; Other \_\_\_\_\_
3. The purpose for the disclosure is (for mental health records, also, how the records are germane to that purpose): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Required by Employer/Job Stability \_\_\_\_\_; Legal \_\_\_\_\_; Family Involvement \_\_\_\_\_  
Insurance Reimbursement \_\_\_\_\_; Aftercare \_\_\_\_\_; Comprehensive Treatment \_\_\_\_\_

4. This consent is subject to revocation at any time except to the extent that \_\_\_\_\_, who is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

A. Date: \_\_\_\_\_

B. Event: 120 Days After Termination of Treatment \_\_\_\_\_  
Or

C. Condition: \_\_\_\_\_

\_\_\_\_\_  
Witnessed By/ Date Witnessed

\_\_\_\_\_  
Client/Patient Signature/Date

\_\_\_\_\_  
Parent/Guardian (if patient is a minor)/Date

\_\_\_\_\_  
Parent/Guardian (if patient is a minor)/Date