Northwest Counseling and Psychotherapy Center

30375 Northwestern Highway, Suite 200
Farmington Hills, MI 48334
Telephone: (248) 254-3332 Fax: (248) 254-3333

Authorization for Release of Confidential Information

Name _____ **Case #**_____

As the _____ Client or ____ Legal Guardian/Legal Representative of the above-named person, I authorize the exchange of information between Northwest Counseling and Psychotherapy Center and _____

_____

_____

Name and telephone number of Person, Agency or Organization; Specific Relationship of Person/Entity to the Client if necessary

concerning my clinical treatment and medical information, which may include verbal or written summaries regarding psychiatric or psychological information and reports, mental health progress, treatment plans and status; substance abuse, hepatitis, sexually transmitted diseases (STDs), tuberculosis, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), human immunodeficiency virus (HIV) and any other communicable diseases as defined by the Michigan Department of Community Health. These releases will be as limited as necessary from my most recent admission for treatment record **as indicated by my initials below**:

_____ Summary of Treatment and Prognosis
_____ Psychiatric/Psychological Evaluations
_____ Medication(s)
_____ Assessments and Intake Information
_____ Referrals/Continuing Care Advice
_____ Other _____

_____ Treatment Planning
_____ Diagnosis
_____ Treatment Progress, Participation
_____ Dates of Service, Treatment Response
_____ School Academic/Conduct Evaluations

_____

Define the specific purpose for the release of above information: _____

_____

I understand that my client records are protected under Federal and State regulations and cannot be disclosed without my written authorization, except as otherwise indicated therein. I understand that this authorization is voluntary, and that if I authorize these disclosures, that I can change my mind and revoke the authorization at any time in writing to NCPC. I understand that I cannot take back disclosures already made with my authorization. **This consent expires automatically (1) In 12 months after the date of my signature; or (2) In one week after termination of services at NCPC.** I also understand that I may be denied services if I refuse to sign this form for treatment, payment or healthcare purposes, where allowed by Michigan law. I understand that I can request a copy of this signed form: _____ I request a copy of this form; _____ I do not wish a copy of this form.

_____

Client or Legal Guardian/Representative Signature **Date**

_____

Therapist/Staff Signature **Date**

Rev 09/09