**Kalamazoo Office**
5340 Holiday Terrace
Kalamazoo, MI 49009
Phone (269) 372-4140
Fax (269) 372-0390

cfps
Child & Family Psychological Services, P.C.

**Portage Office**
1662 E. Centre Ave.
Portage, MI 49002
Phone (269) 321-8564
Fax (269) 321-8641

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

_____ _____
Patient's Full Legal Name Date of Birth

I, _____, hereby authorize _____,
(Name of Patient or Legal Guardian) (Therapist's Name)

of **Child & Family Psychological Services, P.C.** to release/exchange information with _____

_____
(Name of Person or Organization)

_____
(Street Address) (City, State, Zip Code)

☐ Verbal Exchange of Information ☐ Send Information ☐ Obtain Information From

SPECIFIC INFORMATION TO BE DISCLOSED:

Timeframe for records needed: From _____ To: _____

☐ Intake information
☐ Medications prescribed/medication management notes
☐ Progress notes
☐ Summary of treatment
☐ Other _____
(specify)

☐ Assessments
☐ Psychiatric evaluation
☐ Treatment plan
☐ Testing results

Reason for Disclosure: _____

_____

This authorization will expire one year from the date of signature unless otherwise specified. I understand that my records are protected by the State and Federal Confidentiality Rules and cannot be disclosed without my written authorization unless release is required by other regulations. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken. I understand that medical information may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, and ARC. I understand that treatment, payment, or eligibility for services will not be conditioned on signing this authorization. I understand that there is the possibility the protected health information may be re-disclosed by the recipient.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/Guardian/Legal Representative if under 18 Date

_____ _____
Signature of Witness Date

NOTE TO RECEIVING AGENCY: This information has been disclosed to you from records protected by the Mental Health Code 330.1748 and the Federal Privacy Regulations. An individual receiving information made confidential by these regulations shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained. A general authorization for release of medical or other information is NOT sufficient for this purpose.

Date information released/exchanged _____ Initials of person completing request _____