Oakland Psychological Clinic, P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CONFIDENTIAL

(PRINT)

Patient Name:	
Birth Date:	S.S. #:
Other Names Used in Treatment:	

I authorize the disclosure of records about me (or my minor child) between:

Name: Oakland Psychological Clinic, P.C.	
Address: 1455 S. Lapeer Rd. Ste. 175 N	
City, State, Zip: Lake Orion, MI 48360	
Attention:	
Phone: 248-393-5555 Fax: 248-393-1791	

and

Relationship: _____

Name:	
Address:	
City, State, Zip:	
Attention:	
Phone:	Fax:

Information may include any of the following:
Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Initial all that apply to person/organization listed above.)
The authorizing person must place his/her initials next to the type of information to be disclosed:

_____ Appointment Information	_____ Lab Results	_____ Psychiatric Evaluation
_____ Assessment	_____ Physical Examination	_____ Psychological Testing
_____ Dates and/or Completion of Tx	_____ Progress Notes	_____ Thank You Letter
_____ Discharge Summary	_____ Progress Report	_____ Treatment Plans
_____ Financial/Insurance Information	_____ Psychiatric Med. Reviews	_____ Urine Drug Screens
_____ Identifying Information	_____ Other: Specify _____	

Purpose and need for such disclosure: (Initial all that apply to person/organization listed above.)
The authorizing person must place his/her initials next to the purpose for the disclosure:

_____ After Care Planning	_____ Employer Req./Job Stability	_____ Pre-Employment Screening
_____ Assessment of Patient	_____ Emergency Contact	_____ Referral for Services
_____ Continuity of Care	_____ Family Involvement	_____ Social Security Benefits
_____ Disability Benefits	_____ Insurance Benefits	_____ Treatment Planning
_____ Driver's License Appeal	_____ Legal Services/Compliance	_____ Workers Comp. Benefits
_____ Educ. Planning/Placement	_____ Payment	_____ Other: Specify _____

Revocation of authorization: *This Authorization may be revoked by me at any time by my written notice to the above-named individual or organization, except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.*

Without expressed revocation, this consent expires for the following reason(s), whichever is later (check one box):

- ☐ *Date: (One year from discharge unless otherwise specified)* _____
- ☐ *Event:* _____
- ☐ *Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.*

Redisclosure: *While Oakland Psychological Clinic, P.C. does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.*

Patient Signature_____ Date_____
Parent/Legal Guardian Representative_____ Date_____
Witnessed by_____ Date_____

☐ This patient declined communication with their Primary Care Physician and the "Importance of Coordination of Care with Your PCP" was given to him/her.