Patient Name

Patient DOB

MM-DD-YYYY

Date

CONFIDENTIAL

CONSENT TO RELEASE MENTAL HEALTH, MEDICAL, OR SUBSTANCE ABUSE RECORDS

I authorize disclosure of records/information about me between:

Michigan Psychiatric &: Primary Care Clinic, PC and:

Name

Address

City, State, Zip Code

Phone Number

(000) 000-0000

Please enter a valid phone number.

Fax Number

(000) 000-0000

Please enter a valid phone number.

The following information is being requested, please

- [ ] Disclose to the above party:

- [ ] Receive Froim the above party

The following information is being requested, please:

- [ ] Medical HIstory
- [ ] Test Results
- [ ] Other medical (M.D./Nurse evals, notes, orders, medications
- [ ] Social and/or Chemical Use history/assessment
- [ ] Mental Health Assessments/consultations
- [ ] Progress Reports/Notes
- [ ] Change in Condition/aftercare planning
- [ ] Discharge summary
- [ ] Limited Reports (dates, discharge status, aftercare plan)
- [ ] Billing/Payments
- [ ] Other

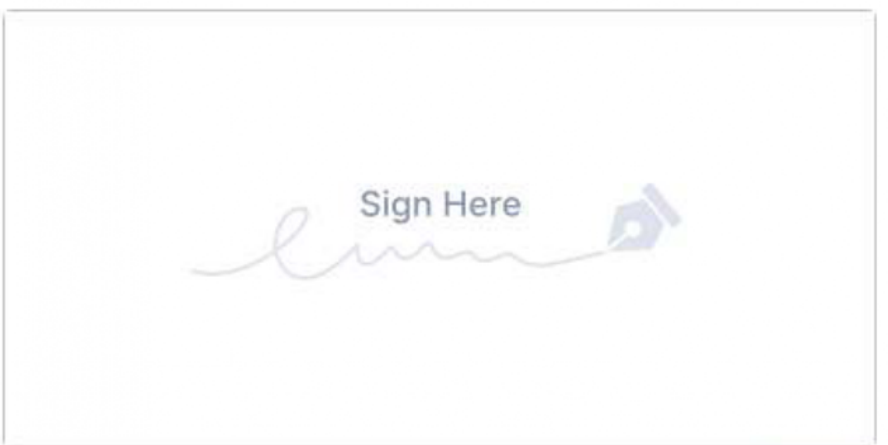
I understand that my chemical dependency records are protected under the federal regulations governing confidentiality of Alcohol and I Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my Mental Health clinic Records are afforded protection under state law. I understand that I can revoke this consent at any time. I understand this communication will reveal my presence as a patient at a treatment facility.

This consent expires one year from today's date unless otherwise specified here

MM/DD/YYYY

Date

Patient Signature



Clear

Date

MM/DD/YYYY

Date