MRN: _____

PATIENT AUTHORIZATION FOR DISCLOSURE
PSYCHOTHERAPY NOTES

Patient Full Name: _____
First Initial Last

I, _____ hereby authorize Henry Ford Health System, its director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format as set forth below. This authorization is for the disclosure of psychotherapy notes only. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.

1. **Name or title of person or organization and address to whom information is to be:**

☑ Disclosed To: Legal Copy Services, Inc.
PO Box 2845
Grand Rapids, MI 49501
Address

☐ Requested From: _____
Address

2. The purpose or need for such disclosure

XXX at the request of the patient ____ Personal Use ____ Continuation of Care XXX Attorney

____ Workman's Compensation ____ Insurance ____ Disability ____ Other _____

3. The psychotherapy notes to be disclosed are for the dates of service indicated below.

Any and all dates of service

4. This authorization is valid only if received by Henry Ford Health System within 90 days of the date signed. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.
5. HFHS does not condition treatment on whether this authorization is signed.
6. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no loner be protected by law.
7. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing information **directly** to a treating physician or health care facility.

Signature: _____ Relationship (if other than patient): _____
Patient, Parent or Minor, Legal Guardian, Personal Representative*

Date: _____

Witness Signature: _____ Date: _____

*If Legal Guardian or Personal Representative, a copy of appropriate documentation is necessary for release.