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:	2360 Linden Road, Suite 300	
City, State, Zip:	Flint, Michigan 48532	
Attention:		
Phone:		Fax:

and

LEGAL COPY SERVICES, INC.
P.O. Box 2845
Grand Rapids, MI 49501-2845
Voice: (616) 949-1614; Fax: (616) 949-6472

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, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and hepatitis.

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

_______ Admission/Identifying Information
_______ Appointment Information
_______ Assessment
_______ Dates of Treatment/Completion of Program
_______ Discharge Summary
_______ Emergency Contact
_______ Financial/Insurance Information
_______ Lab Results
_______ Other ________________________
_______ Physical Examination
_______ Progress Notes
_______ Progress Report
_______ Psychiatric Evaluation
_______ Psychiatric Medication Reviews
_______ Psychological Testing
_______ Thank You Letter
_______ Treatment Plans
_______ Urine Drug Screens

Purpose and need for such disclosure: (Initial all that apply to person/organization listed above.)
The authorizing person must place their initials next to type of information to be disclosed:

_______ After Care Planning
_______ Assessment of Patient
_______ Continuity of Care
_______ Disability Benefits
_______ Drivers License Appeal
_______ Other – Specify ________________________
_______ Educational Planning/Placement
_______ Employer Request/Job Stability
_______ Family Involvement
_______ Insurance Benefits
_______ Legal Services/Compliance
_______ Payment
_______ Pre-Employment Screening
_______ Referral for Services
_______ Social Security Benefits
_______ Treatment Planning
_______ Workers Comp. Benefits

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 specified 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.*

Patient Signature________________________ Date____________

Parent/Legal Guardian Representative________________________ Date____________

Witnessed by________________________ Date____________