

TOTAL HEALTH CARE OF MICHIGAN, P.C.

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____ its Director of designee, or Medical Record Department, to release information contained in my patient/client record (or that of my minor child, _____) to the person or organization listed below. Information may include any of the following: alcohol and drug abuse records protected under regulations in 42 CFR, if any, physician records psychological service records, if any and social service records, if any.

1. Name, title, address and organization to whom disclosure or exchange of information is to be made:

Name/Title or Relation: _____
Company/Organization: Legal Copy Services, Inc. _____
Address, City/State/Zip: PO Box 2845, Grand Rapids, MI 49501 _____
Phone Number: (877)949-1313 _____ Fax Number: (616)949-6472 _____

2. Specific type or extent of nature of information to be disclosed (The patient must initial next to each box that is checked):

- Assessment Discharge Summary Identifying Information
- Psychiatric Eval. Physical Exam Progress Report
- Psychological Eval. Other _____

3. Purpose and need for such disclosure (check the appropriate boxes):

- Referral of Services Assessment of patient Coordination of Care
- Case Planning Other Civil Litigation _____

4. Without expressed revocation this consent expires for the following specific reason:

- 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: _____

Date of Birth: _____ Social Security No.: _____

Parent/Legal Guardian Representative: _____

Witnessed by: _____ Date: _____