

Authorization for Release of Information

I request information regarding _____

Full Name: First Middle Initial Last

(/ /) be given:

Date of Birth

___ **To** ___ **From:** Monica Michael, MA, LPC, LLC
Rimrock Professional Building
4701 Plainfield Ave. NE, Suite C
Grand Rapids, MI 49525

Email: monica.m.michael@gmail.com Fax: 616.361.3395

___ **From** ___ **To:** _____

Specific Records/Information to be Released:

- ___ All Records
- ___ Summaries (Including Intakes, Evaluations, Status Reviews and Discharge Summaries)
- ___ Treatment Plans
- ___ Psychiatric/Psychological Evaluations and Testing
- ___ Alcohol or other Drug Abuse
- ___ Verbal Exchange of Information
- ___ Written Exchange of Information
- ___ Other(s): _____

For the Purpose of:

- ___ Continuing Care
- ___ Coordination of Services
- ___ Counselor Supervision
- ___ Other(s): _____

This release will expire: _____ (one year maximum)

I understand that I may withdraw this authorization in writing at anytime, unless action has already been taken based on this consent.

Client Signature (or client guardian) Date

Witness Signature Date

The information released with this authorization is confidential. Further disclosure of this information is prohibited unless otherwise permitted by federal and/or state laws.