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

5242 Plainfield Ave. NE, Suite C

Grand Rapids, MI49525-1084

Email: monica.m.michael@gmail.com Fax: 616.734.6205

___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.

_____ Date: _____

Client Signature (or client guardian)

_____ Date: _____

Witness Signature

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