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 Avenue NE
Suite C
Grand Rapids, MI 49525-1084

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.