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
6140 28th Street SE, Suite 110
Grand Rapids, MI 49546

Email: monica.m.michael@gmail.com

___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.