

Release of Information

Client Name: _____ Date of Birth: _____ Michigan Tech "M" #: _____

I hereby request and authorize Counseling Services to (check one):
_____ Disclose to
_____ Receive from
_____ Exchange with

Name: _____
Street address: _____ City, State, Zip: _____
Phone/Fax: _____

The following specific information from my records:
Dates of treatment: _____

Type of treatment: _____ Mental Health _____ Alcohol/Drug _____ Other (specify): _____

INFORMATION TO BE RELEASED:

- | | | |
|--|---|---|
| <input type="checkbox"/> Academic Performance | <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Assessment Summary |
| <input type="checkbox"/> Date of Screen/Hospitalization | <input type="checkbox"/> Discharge/Continue Care | <input type="checkbox"/> Education Evaluation |
| <input type="checkbox"/> Letters | <input type="checkbox"/> M.D. Notes | <input type="checkbox"/> Medical Log/History |
| <input type="checkbox"/> Person-Centered Plan | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Progress/Activity Note |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Questionnaires |
| <input type="checkbox"/> Radiology/Lab Reports | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Verbal Information |
| <input type="checkbox"/> Other ("all records" not acceptable), please specify: _____ | | |

The purpose of such disclosure is: _____

This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this authorization at any time except to the extent that information already released pursuant to this consent cannot be recalled. Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (42 CFR Part 2.35).

The authorization is effective for one year from the date of signing or as specified by the condition:

Signed Patient/Client: _____ Date: _____
Signed Parent/Guardian/Other (specify): _____ Date: _____
Signed Witness: _____ Date: _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.
(FAX/COPY EFFECTIVE AS ORIGINAL)