

Oakland Psychological Clinic, P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CONFIDENTIAL

(PRINT)

I authorize the disclosure of records about me (or my minor child) between:

Name: Oakland Psychological Clinic, P.C.
Address: 1455 S. Lapeer Rd. Ste. 175 N
City, State, Zip: Lake Orion, MI 48360
Attention:
Phone: 248-393-5555 Fax: 248-393-1791

and

Patient Name:
Birth Date: S.S. #:
Other Names Used in Treatment:

Relationship:

Name:
Address:
City, State, Zip:
Attention:
Phone: Fax:

Information may include any of the following:

Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Initial all that apply to person/organization listed above.)

The authorizing person must place his/her initials next to the type of information to be disclosed:

☐ Appointment Information	☐ Lab Results	☐ Psychiatric Evaluation
☐ Assessment	☐ Physical Examination	☐ Psychological Testing
☐ Dates and/or Completion of Tx	☐ Progress Notes	☐ Thank You Letter
☐ Discharge Summary	☐ Progress Report	☐ Treatment Plans
☐ Financial/Insurance Information	☐ Psychiatric Med. Reviews	☐ Urine Drug Screens
☐ Identifying Information	☐ Other: Specify _____	

Purpose and need for such disclosure: (Initial all that apply to person/organization listed above.)

The authorizing person must place his/her initials next to the purpose for the disclosure:

☐ After Care Planning	☐ Employer Req./Job Stability	☐ Pre-Employment Screening
☐ Assessment of Patient	☐ Emergency Contact	☐ Referral for Services
☐ Continuity of Care	☐ Family Involvement	☐ Social Security Benefits
☐ Disability Benefits	☐ Insurance Benefits	☐ Treatment Planning
☐ Driver's License Appeal	☐ Legal Services/Compliance	☐ Workers Comp. Benefits
☐ Educ. Planning/Placement	☐ Payment	☐ Other: Specify _____

Revocation of authorization: This Authorization may be revoked by me at any time by my written notice to the above-named individual or organization, except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.

Without expressed revocation, this consent expires for the following reason(s), whichever is later (check one box):

- ☐ Date: (One year from discharge unless otherwise specified) _____
- ☐ Event: _____
- ☐ Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

Redisclosure: While Oakland Psychological Clinic, P.C. does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.

Patient Signature _____ Date _____

Parent/Legal Guardian Representative _____ Date _____

Witnessed by _____ Date _____

☐ This patient declined communication with their Primary Care Physician and the "Importance of Coordination of Care with Your PCP" was given to him/her.

Admin/Forms/Clinic/7/10; 8/12; 11/14