Heron Ridge
Associates., PLC

Clarkston
3694 Clarkston Rd
Suite D
Clarkston, MI 48348
P: 248-693-8880
F: 248-693-8457

Bingham Farms
31000 Telegraph Rd
Suite 120
Bingham Farms, MI
48025
P: 248-594-4991
F: 248-594-4992

Ann Arbor
1785 W. Stadium Blvd
Suite 203C
Ann Arbor, MI 48103
P: 734-913-1093
F: 734-369-2683

Plymouth
705 South Main St.
Suite 280
Plymouth, MI 48170
P: 734-454-3560
F: 734-454-3570

Client: _____
DOB: _____

I authorize the use of disclose of the above individual's health information as described below:

The following individual(s) or organizations are authorized to make disclosure (***send***):

From:

- Heron Ridge Clarkson
- Heron Ridge Bingham Farms
- Heron Ridge Ann Arbor
- Heron Ridge Plymouth
- Other (please provide name, address and phone):
  Name: _____

  Address: _____

  _____

  _____

  Phone: _____
  Fax: _____

I authorize the use of disclose of the above individual's health information as described below:

The following individual(s) or organization(s) are authorized to ***receive*** disclosure:

To:

- Heron Ridge Clarkson
- Heron Ridge Bingham Farms
- Heron Ridge Ann Arbor
- Heron Ridge Plymouth
- Other (please provide name, address and phone):
  Name: _____
  Address: _____

  _____

  _____

  Phone: _____
  Fax: _____

The purpose and need for such disclosure:

____Diagnosis	____Drug/Alcohol History	____Treatment Summary
____Attendance	___ Mental Status Exam	___ Treatment Progress
____Prognosis	____Physical Examination	____Discharge Summary
____Medication Review	____Intake/Assessment	____Psychiatric Evaluation
____Disability Forms (LTD/STD)		____ Laboratory Results
____Emergency Records	___School Records-Specify_____	

____Other-Specify_____

The authorizing person must place their initials next to the purpose/need for such disclosure:

____Provision of Behavioral Health Services	____Billing Purposes	____Social Security
____Emergency Contact	____Family Involvement	____Continuity of Care
____Emergency Request	____Worker's Compensation	____Aftercare Planning
____Disability Certification	____Attorney Inquiry	

____Other-Specify_____

I understand that my record may contain sensitive information, including alcohol and drug abuse records protected under 42 code of Federal Regulations, Part 2, if any; psychological services records, if any, including communications made by me to a psychiatrist, social worker, or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC.

I also understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest to a claim under my policy.

This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire in one year from the date I sign it.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of this information is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of client or legal representative Date

_____

Print your name

If signed by legal representative, relationship to patient: _____

_____ _____

Witness Date

Date Records sent: _____initials _____

Notes: _____

6/2014 jas