HERON RIDGE ASSOCIATES, PLC

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ DOB ___/___/____, hereby authorize

Name:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____

Its Director or Designee, or Medical Records Department, to release information contained in my client records, 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, to individuals or organizations listed below, only under the conditions listed below:

TO/FROM HERON RIDGE ASSOCS., PLC:

3694 Clarkston Rd Suite D Clarkston, MI 48348 Phone: 248-693-8880 Fax: 248-693-8457	31000 Telegraph Rd Suite 120 Bingham Farms, MI 48025 Phone: 248-594-4991 Fax: 248-594-4992	1785 West Stadium Blvd Suite 203 Ann Arbor, MI 48103 Phone: 734-913-1093 Fax: 734-369-2683	705 South Main St Suite 280 Plymouth, MI 48170 Phone: 734-454-3560 Fax: 734-454-3570

I understand that my protected health information disclosed under this authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

This release of information is ( ) is not ( ) a reciprocal release of information.

2. Specific type of information to be disclosed:

THE AUTHORIZING PERSON MUST PLACE THEIR INITIALS NEXT TO THE TYPE OF INFORMATION TO BE DISCLOSED.

____Diagnosis	____Drug/Alcohol History	____Treatment Summary
____Attendance	____Mental Status Exam	____Treatment Progress
____Prognosis	____Physical Examination	____Discharge Summary
____Medication Review	____Intake/Assessment	____Psychiatric Evaluation
____Emergency Only	____School Records-Specify_____	
____Other-Specify_____		

3. The purpose and need for such disclosure:

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_____		

4. This consent can be revoked, in writing, at anytime except to the extent that information has been already released by the Facility. Any consent for the release of drug and alcohol abuse records shall end when the purpose for the release has been

achieved.

5. This consent will expire automatically when the purpose for the release has been achieved or upon 365 days (1 year) after the date below, whichever is later.

Signature of Client:_____ Date:_____

Birth Date of Client:_____ Social Security Number of Client:_____

CONSENT OF LEGAL GUARDIAN, CLIENT ADVOCATE, OR NEAREST RELATIVE IF CLIENT IS UNABLE TO SIGN OR IS A MINOR

Signature of Legal Guardian, Client Advocate, or Personal Representative:_____

Date:_____ Relationship:_____

Address:_____ Phone Number:_____

Signature of Witness:_____ Date:_____

Dates records sent:_____ Initials:_____