



LAKES PSYCHIATRIC CENTER
 CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name:
Birth Date:
Other Names Used in Treatment:

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

Name: Lakes Psychiatric Center
Address: 2300 Haggerty Road Suite 2160
City, State, Zip: West Bloomfield, MI 48323
Attention:
Phone: 248-859-2457 Fax: 248-859-2473

and

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: (Check all that apply to person/organization listed above.)

<input type="checkbox"/> Identifying Information	<input type="checkbox"/> Financial/Insurance Information	<input type="checkbox"/> Psychiatric Med. Reviews
<input type="checkbox"/> Appointment Information	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Assessment	<input type="checkbox"/> Physical Examination	<input type="checkbox"/> Thank You Letter
<input type="checkbox"/> Dates and/or Completion of Tx	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Report	<input type="checkbox"/> Urine Drug Screens
<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Psychiatric Evaluation	

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

<input type="checkbox"/> After Care Planning	<input type="checkbox"/> Educational Planning/Placement	<input type="checkbox"/> Payment
<input type="checkbox"/> Assessment of Patient	<input type="checkbox"/> Employer Request/Job Stability	<input type="checkbox"/> Pre-Employment Screening
<input type="checkbox"/> Continuity Care	<input type="checkbox"/> Family Involvement	<input type="checkbox"/> Referral for Services
<input type="checkbox"/> Disability Benefits	<input type="checkbox"/> Insurance Benefits	<input type="checkbox"/> Social Security Benefits
<input type="checkbox"/> Drivers License Appeal	<input type="checkbox"/> Legal Services/Compliance	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> Other		<input type="checkbox"/> Worker Comp. Benefits

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):

<input type="checkbox"/>	<i>Date: (One year from discharge unless otherwise specified) _____</i>
<input type="checkbox"/>	<i>Event: _____</i>
<input type="checkbox"/>	<i>Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.</i>

Redisclosure: *While Lakes Psychiatric Center 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 _____