AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, ______________________________ hereby authorize Tree of Life Counseling Services LLC
(Client's name)
its Director or designee, or Medical Records Department, to release information contained in my records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychological services records, if any, and social services records, if any, including communications made by me to a social worker or psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by MCLA 333.5131 which includes venereal diseases, tuberculosis, HIV, AIDS or ARC, if any, to the individual or organization listed. ***Note:* *42 Code of Federal Regulations, Part 2, prohibits redisclosure of alcohol and drug abuse records protected under the regulation.***

Name of person(s) or organization(s) to whom disclosure is to be made: ______________________________

1. Specific type of information to be disclosed: (client initials to left of category)

______ ☐ Diagnosis	______ ☐ Drug/Alcohol History	______ ☐ Treatment Summary
______ ☐ Attendance	______ ☐ Mental Status Exam	______ ☐ Prognosis
______ ☐ Progress Review	______ ☐ Physical Examination	______ ☐ Recommendations
______ ☐ Discharge Summary	______ ☐ Photos	______ ☐ Other ______________
	______ ☐ Audio/Videotapes	______________
		______________

2. The purpose and need for such disclosure:

☐ Provision of Behavioral Health Services	☐ Billing Purposes	☐ Aftercare Planning
☐ Continuity of Treatment	☐ Significant Other Involvement	
☐ Other ______________		

3. This consent can be revoked at any time by providing written notification except to the extent that information has already been released. Revoked Date__________ Signature______________

4. Without expressed revocation, this consent expires in one year from the date signed unless otherwise indicated below: (Client initials to left of category) Any consent for release of information or records shall end when the purpose for release has been achieved.

   A. ______ Date______________________________ (Not to exceed one year)
   or
   B. ______ Event______________________________
   or
   C. ______ Condition______________________________
   or
   D. ______ For a one-time release of information, expires______________ (Not to exceed 90 days)

______________________________ Witnessed by	______________________________ Client's Signature
______________________________ Printed Name	______________________________ (and Parent or Guardian's Signature where appropriate)
______________________________ Date Witnessed	______________________________ Printed Name
	______________________________ Birth Date of Client / Last 4 Numbers of Social Security of Client
☐ Copy to Client	☐ Parent of Minor ☐ Legally Appointed or Guardian Ad Latium ☐ DHS Worker for Permanent Ward of the Court
	______________________________ Date Signed