CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name:______________________________ Date of Birth:______________

Street Address:______________________________City:__________State:__________ZIP:__________

Main Number:______________________ Cell Phone: ______________________________

I authorize the disclosure of records about me (or my minor child) between
Abaris Behavioral Health
and the person/organization identified below:

Name of Person/Organization ____

Address______________________________ City ____________ State __________ ZIP code: ____________

Phone______________________________FAX______________________________

Information to be released

Please specify type of information to be disclosed: *(Check all that apply to person/organization listed above)*

☐ Dates of Treatment Episode(s)	☐ Discharge Summary	☐ Psychiatric Med. Reviews
☐ Medical Information/ Labs	☐ Psychiatric Evaluation	☐ Psychological Testing
☐ Biopsychosocial Assessment	☐ Treatment Plans	☐ Other:

Purpose of Release

☐ Coordination of Care	☐ Educational Planning	☐ Legal Services/Compliance
☐ Disability / Social Security	☐ Insurance Issue	☐ Treatment Planning
☐ Family Involvement	☐ Worker's Comp. Benefits	☐ Other:

I authorize information as indicated above. I understand that this authorization in voluntary. In addition, I understand that my records are protected under federal regulations that include alcohol or substance use, as well as information protected under regulations in code 42, part 2, psychological service records, social services records, HIV, communicable disease information, including communications between a mental health provider and you. 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. Upon release, this health information is no longer protected by Abaris Behavioral Health and has the potential to be re-disclosed by the recipient. This authorization does not authorize Abaris Behavioral Health to discuss my health information or medical care with anyone other than the individual or agency identified on this form. Abaris Behavioral Health is released from all legal liabilities for the release of the above requested information.

This statement of consent can be revoked at any time and expires on __________ (event or date). If no expiration date or identifiable event is listed, then the authorization expires 12 months after it is signed unless cancelled by me in writing (my cancellation will take affect when the individual or agency releasing information receives my notice in writing). I am authorizing disclosure of information protected under the federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer protected by state and federal law.

Signature of Patient: ______________________________ Date: ______________

Signature of Parent/Guardian: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

Novi: 40000 Grand River Ave, Suite 306. Novi, Michigan 48375. Phone: 248-426-9900 Fax: 248-426-9950
Rochester Hills: 3950 S. Rochester Rd, Suite 2250. Rochester Hills, Michigan 48307. Phone: 248-650-8383 Fax: 248-650-4343
Shelby Township: 51221 Schoenherr Rd, Suite 107. Shelby Township, Michigan 48315. Phone: 586-360-7745 Fax: 586-799-4006