LIFESPAN CLINICAL SERVICES
35300 Nankin Blvd., Suite 601
Westland, MI 48185

AUTHORIZATION AND CONSENT TO DISCLOSE INFORMATION

Client Name: _____ DOB: _____

Address: _____ S.S.#: _____

I, _____, authorize Lifespan Clinical Services

to disclose information in my _____ records to:

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

(complete name and address of facility)

Specific information to be disclosed: (**you may not request (all) or (entire) TX record you must specify)**
You must sign your initials next to each item to be disclosed

_____ **Assessment**
_____ Discharge Summary
_____ Treatment Plan/IPOS
_____ **Medication Reviews**
_____ **Psychiatric Evaluation**
_____ Treatment Plan Review/IPOS Review
_____ Psychological Test Report

Please see enclosed Subpoena or Letter Request for information to be disclosed. **X** Other

This consent authorizes Lifespan Clinical Services to disclose information contained in the client's records, including alcohol and substance abuse records, if any; Social Services records, if any; HIV, AIDS, ARC records, if any.

Purpose or need for disclosure: **You must sign your initials next to each purpose that applies.**

_____ Provision of Mental Health Services
_____ Family Involvement
_____ Billing Purposes
_____ Aftercare Planning
_____ Continuity of Treatment
_____ **Coordination of Care**
FOR DISCOVERY BEFORE TRIAL **X** Other.

If release to self, complete statement below.

I, _____, accept full responsibility for confidential records received from Lifespan Clinical Services.

_____.
Signature

I understand that my treatment records are protected under the federal regulations governing confidentiality of patient records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act of 1996 ('HIPPA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that any notice to revoke this consent must be in writing and that in any event, this consent expires automatically as follows:

Six months from date of signature or _____
(discharged from treatment, specification of the date, event, or condition upon which this consent expires)

_____
Client/Parent/Guardian Signature Date

* Copy of this completed form was given to Client/Parent or Guardian