CON ID/Case # ____________

CONSENT TO RELEASE, OBTAIN OR EXCHANGE INFORMATION

I, ____________ hereby authorize Oakland Family Services, its Director or designee, or Medical Records Department to: ☑**RELEASE** ☐**OBTAIN OR** ☐**EXCHANGE** 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 or organization to whom disclosure/obtain/exchange is to be made: ____________

RECORDS DEPOSITION SERVICE, INC.

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

1. Specific type of information to be disclosed:

☐Diagnosis	☐Mental Status Exam	☐Progress Report
☐Attendance	☐Psychiatric Evaluation	☐Drug/Alcohol Screen
☐Treatment Summary	☐Prognosis	☑Other PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST
☐Discharge Summary	☐Recommendations	
☐Drug/Alcohol History	☐Physical Examination	

2. The purpose and need for such disclosure:

☐Provision of Behavioral Health Services	☐Billing Purposes	☐Aftercare Planning
☐Significant Other Involvement	☑Legal Issues	☐Continuity of Treatment

☐Other ____________

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

A.) Without expressed revocation, this consent expires in one year from the date signed unless otherwise indicated below. Any consent for release of information or records shall end when the purpose for release has been achieved.

OR

B.) For a one-time release of information, expires ____________ (not to exceed 90 days)

____
Client's Signature

____
(Parent or Guardian's signature where appropriate)
☐Parent of Minor ☐Legally Appointed Guardian
☐Foster Parent/Foster Care Worker

____
Birthdate of Client

____
Last 4 numbers of Social Security of Client

____
Parent or Guardian Printed Name

____
Date Signed

☐Copy to Client

*Revoked Date ____________ Signature ____________