OAKLAWN HOSPITAL PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM

15209 West Michigan Avenue, Marshall, Michigan 49068
269/781-7850/Fax 269/781-7872

Client Information Release Authorization

I, ______________________, ______________, ______________________________
(Client's Name) (Date of Birth) (Client Address)

hereby authorize **Oaklawn Hospital Psychiatric Partial Hospitalization Program and/or Oaklawn Psychological Services - 15209 W. Michigan Avenue, Marshall, MI 49068, and/or Oaklawn Hospital Psychiatric Center, 200 N. Madison, Marshall, MI 49068**
(Name and Address of Person or Organization)

to release and/or exchange any and all information, whether generated by or received by Oaklawn Psychiatric/Psychological Service(s), contained in my client records throughout the duration of my admission(s)/treatment (including all psychiatric, substance abuse, HIV and/or AIDS information if any contained therein) to the individuals or organizations and only under the conditions listed below. (My signature authorizes that a Photostat copy or Facsimile copy of this document is as valid as the original):

1. Name or title of person(s) and/or organization and address to whom disclosure is made:

   RECORDS DEPOSITION SERVICE, INC.
   PO BOX 5054
   SOUTHFIELD, MI 48086-5054

   P: 248.357.3330
   F: 248.357.3337

2. Specific type of information to be disclosed: ______________________________

   ____

   ____

3. The purpose or need for such disclosure: FOR DISCOVERY BEFORE TRIAL

   ____

4. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in compliance with this consent form. If not previously revoked, this consent will terminate upon:

   A. Date: **Six months from date of signature.**

   B. Event: ______________________________

   or

   C. Condition: ______________________________

______________________ (Witnessed by)

______________________ (Client's Signature)

______________________ (Date Witnessed)

______________________ (Date Signed)

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