Pioneer Counseling Center

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth:_____ Social Security #: _____

I, _____ authorize the information specified below to be disclosed as follows:

From: **Pioneer Counseling Center**

To: Name of Person: _____

Organization: **RECORDS DEPOSITION SERVICE**

Address: **PO BOX 5054**
SOUTHFIELD, MI 48086-5054

P: (248) 357-3330
F: (248) 357-3330

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment by Pioneer Counseling Center (Check off YES or NO for each item):

	Yes	No
Assessment and Diagnostic Summaries	☐	☐
Psychiatric Evaluations	☐	☐
Medication Regime	☐	☐
Laboratory Information (Excluding HIV)	☐	☐
Attendance Record	☐	☐
Progress Notes: Specify dates _____	☐	☐
Verbal Exchange	☐	☐
Discharge Summary	☐	☐
Other: Specify_____	☐	☐

If information in my records pertains to HIV or AIDS, I expressly do ☐ do not ☐ authorize Pioneer Counseling Center to disclose such information pursuant to this authorization. ☐ Not applicable Please Initial _____

I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Pioneer Counseling Center and its affiliates, representatives, and assigns from all legal liabilities that may result from the release of this information.

I acknowledge that I have the right to revoke this authorization at any time, by sending written notification to the medical records department of Pioneer Counseling Center. I understand that a revocation is not effective if Pioneer Counseling Center already has taken actions in reliance on the authorization.

I am requesting that this information be disclosed for the purpose(s) of: **DISCOVERY BEFORE TRIAL**.

This authorization shall be in full force and effect until _____. If no expiration date is provided, this authorization shall expire one hundred eighty (180) days after the date on which I signed below.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.

I understand that Pioneer Counseling Center will not condition my treatment, payment, or enrollment or eligibility for benefits on whether I provide this authorization.

_____ _____

Client signature/Legal guardian signature (if applicable) **Date**

_____ _____

Legal guardian name (print) **Indicate Authority to Sign**

_____ _____

Witness Signature **Date**

Notice to recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996(45 C.F.R. §160-164), as well as 42 C.F.R. Part 2 and 42 U.S.C. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be redisclosed without the specific written consent of the individual about whom such information pertains.

Revised: 10/99,4/11/2003,8/2004