Oakland Psychological Clinic, P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CONFIDENTIAL

(PRINT)

Patient Name:	
Birth Date:	S.S. #:
Other Names Used in Treatment:	

I authorize the disclosure of records about me (or my minor child) between:

Name: Oakland Psychological Clinic, P.C.
Address: 1455 S. Lapeer Road, Suite 175N
City, State, Zip: Lake Orion, MI 48360
Attention: Medical Records
Phone: 248-393-5555 Fax: 248-393-1791

and

Relationship: _____

Name: Record Deposition Service, Inc.
Address: 27355 W. Eleven Mile Road
City, State, Zip: Southfield, MI 48086-9877
Attention:
Phone: 248-357-3330 Fax: 248-357-3337

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.

Specific type of information to be disclosed: (Initial all that apply to person/organization listed above.)
The authorizing person must place their initials next to type of information to be disclosed:

X Identifying Information	X Financial/Insurance Information	_____ Psychiatric Med. Reviews
_____ Appointment Information	_____ Lab Results	_____ Psychological Testing
X Assessment	_____ Physical Examination	_____ Thank You Letter
_____ Dates and/or Completion of Tx	X Progress Notes	_____ Treatment Plans
X Discharge Summary	_____ Progress Report	_____ Urine Drug Screens
_____ Emergency Contact	_____ Psychiatric Evaluation	
_____ Other – Specify _____		

Purpose and need for such disclosure: (Initial all that apply to person/organization listed above.)
The authorizing person must place their initials next to type of information to be disclosed:

_____ After Care Planning	_____ Educational Planning/Placement	_____ Payment
_____ Assessment of Patient	_____ Employer Request/Job Stability	_____ Pre-Employment Screening
_____ Continuity of Care	_____ Family Involvement	_____ Referral for Services
_____ Disability Benefits	_____ Insurance Benefits	_____ Social Security Benefits
_____ Drivers License Appeal	X Legal Services/Compliance	_____ Treatment Planning
_____ Other – Specify _____		_____ Workers Comp. Benefits

Revocation of authorization: *This Authorization may be revoked by me at any time by my written notice to the above named individual or organization, except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.*

Without expressed revocation, this consent expires for the following reason(s), whichever is later (check one box):

- ☐ *Date: (One year from discharge unless otherwise specified)* _____
- ☐ *Event:* _____
- ☐ *Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.*

Redisclosure: *While Oakland Psychological Clinic, P.C. does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.*

Patient Signature_____ Date_____
Parent/Legal Guardian Representative_____ Date_____
Witnessed by_____ Date_____