michigan school psychological clinic

power to grow

Standard Authorization for Disclosure of Mental Health Treatment Information

I,_____, whose Date of Birth is_____,
Authorize Michigan School Psychological Clinic to disclose to and/or obtain from:

_____
(Name, Address, Phone, Fax Number)

the following information:

_____Assessment

_____Diagnosis

_____Psychosocial Evaluation

_____Treatment Plan or Summary

_____Presence/Participation in/and Date Range

_____Educational Information

_____Demographic Information

_____Psychotherapy Notes

_____Progress in Treatment

_____Discharge/Transfer Summary

_____Other_____

Purpose:
This information may be used or disclosed in connection with mental health treatment. If the purpose is other than specified above, please specify:

_____

Revocation:
I understand that I have a right to revoke this authorization, in wirting, at any time by sending written notification to Michigan School Psychological Clinic, 26811 Orchard Lake Rd., Farmington Hills, MI 48334. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
Unless sooner revoked, this authorization expires on the following date:_____ or as otherwise indicated:_____

Conditions:
I further understand that the Clinic will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure:
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law apples that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records

Client Signature Date

Signature of parent, Guardian or Personal Representative Date, if under 18 years Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (e.g., power of attorney, healthcare surrogate, etc.)

Check _____, if client refuses to sign authorization

Staff Signature Date