LAKE ORION COUNSELING CENTER, LLC
AUTHORIZATION REGARDING HEALTH CARE INFORMATION

PATIENT NAME_____ Date of Birth_____

A. Please release health care information to/from_____

B. Please request health care information to/from: _____

(Address) _____

_____

1. I _____hereby authorize the designee to release information contained in my records, including alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, if any; medical service record, if any; psychological or mental health service records, if any; social services records; if any; including communications made by me to a physician, psychologist, social worker, or other health care provider; and information regarding communicable diseases and serious communicable diseases and infections which, as defined by Michigan Department of Public Health Rules, include venereal disease (VD), tuberculosis (TB), Hepatitis B, human immunodeficiency syndrome (AIDS), and AIDS related complex, (ARC), if any, to the individual(s), and/or organization(s) listed below and only under the conditions listed.

2. Specific type of health care information to be disclosed: _____

_____

3. Purpose and need for disclosure: _____

_____

4. This consent can be revoked at any time unless Lake Orion Counseling Center, LLC or its staff has taken actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given for alcohol and/or drug abuse records shall have a duration not longer than that which is reasonably necessary to achieve the purpose for which it is given. I may cancel this authorization in writing, knowing that it would not affect any action already taken based upon my original request. Once the designee gives out the information they have no control over it and the privacy laws may not protect it.

6. This Consent is subject to revocation at any time except in those circumstances in which the Clinic has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, and consent given with respect to alcohol and/or drug abuse records shall have duration no longer than reasonably necessary to effectuate the purpose for which it was given.

   Without expressed revocation this consent expires after 60 days or for the following specified reasons:

   Date: _____ or Event: _____

7. Form of Release

   A. Written_____ B. Verbal _____ C. Audio _____

   D. Video_____ E. Electronic _____ F. Other _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date