**PSYCHOLOGY ASSOCIATES OF GRAND RAPIDS, PC**

**Phone: (616)458-4444 Fax: (616)458-4440**

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____Date of Birth: _____

- ☐ I authorize my clinician_____ and/or his/her administrative staff to _____ release and/or obtain _____ by means of verbal, written, photocopy, or fax, certain confidential information about my psychiatric and/or medical treatment. This information may contain information regarding testing/treatment for HIV, AIDS virus and/or substance abuse under the provisions of P.A. 258 of 1974 as amended, Section 748 Subsection 5.

☐ Treatment Summary ☐ Psychiatric/Psychological Evaluation ☐ Physical Exam
☐ Psychological Testing ☐ Psychotherapy Notes ☐ Laboratory Studies
☐ Emails or Phone Notes ☐ Other _____
☐ Exclude the following information: _____

This information should be released to/obtained from: (name, address, phone/fax)

_____
_____

Purpose of Disclosure:

☐ Continuation of care/discharge planning ☐ Legal Purposes ☐ Personal Use
☐ Coordination of Treatment Services ☐ Termination of Treatment ☐ Other:_____

I am also aware of all consequences that might occur as a result of signing this consent form or of my refusal to do so. My signature means that I have read this form and/or have had it read to me and explained in a language I can understand.

**Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to Psychology Associates of Grand Rapids, PC 1000 Parchment Dr. SE, Grand Rapids, MI 49546.

**Expirations or termination of authorization:** This authorization will expire at the end of the calendar year in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our Privacy Manager, in writing if you decide to terminate the authorization prior to the normal expiration date.

Date to expire if prior than end of calendar year: _____

**Redisclosure:** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Psychology Associates of Grand Rapids, PC.

**Non-conditioning Statement:** If the patient does not consent to this release, his/her treatment will not be compromised in any way.

A true and exact photostatic/faxed copy of this authorization shall have the same effect as the original.

_____

Patient/Guardian Signature Date Signed Witness

_____

Office Use: (list records that were released)