Great Northern Counseling
AUTHORIZATION FOR RELEASE AND DISCLOSURE AND/OR REQUEST FOR MEDICAL INFORMATION AND RECORDS

814 South Otsego Avenue, Ste. E, Gaylord, Michigan, 49735-2708
Telephone (989) 930-4610 Fax (989) 930-4682

I (client/parent/guardian/authorized representative) _____

(My Date of Birth) _____ hereby authorize **Great Northern Counseling** to:

Check one or both or the form in invalid:

_____release information from my medical records to the individual/organization listed below

_____request information from the individual/organization below

Name: _____

Address: _____

Phone: _____ Fax: _____

For the following use or need: _____

_____

The following information from my psychiatric/medical records may be disclosed for dates from/to:

From: _____ To: _____

_____Treatment Summary _____Psychiatric Evaluation _____Psychological Testing

_____Treatment Plan _____Initial Assessment _____ Clinical Progress Notes

Other: _____

Exclude the following information: _____

_____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/Aids related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of Great Northern Counseling, 814 South Otsego Ave., Ste. E, Gaylord, MI. 49735-2708 ATTENTION: Jeffrey Katke, LPC and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, redisclosure of this information is prohibited by the Michigan Mental Health Code sections 748, 749, and 750 of the Public Act 258 of 1974 as amended and also by Title 42 of the Code of Federal Regulations, Part II, with which this authorization complies. The released information may not be copied, shared, or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to

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sign this authorization and that Great Northern Counseling will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued this authorization will expire 1 year from the date indicated after my signature or upon the following date, event, or condition: _____

_____

I have had the opportunity to have this form explained to me and my questions answered (please check 1 box):

Yes: _____ No: _____

Patient/Parent/Legal Guardian/Personal Representative's Signature required (must be 18 years or older and if not the client must be legally authorized to sign on behalf of the client):

Print: _____ **Signature**: _____ **Date**: _____

Relationship to the Client: _____

A copy of this authorization was offered. Copy was provided? Yes: _____ **No**: _____

Witness Signature: _____ **Date:** _____