Life's Light and Hope, PLLC Sara E. Collins, LMSW
Phone: (734) 582-4294
Fax: (734) 468-0106

Release/ Authorization of the Exchange of Information

Client: _____ DOB: _____

I authorize the disclosure of the above individual's health information as described below:

The following individual(s) or organizations are authorized to disclose (send) PHI (Personal Health Information)

Life's Light and Hope, PLLC

42239 Ann Arbor Rd.
Plymouth MI 48170

Ph: (734) 582-4294
Fax: (734) 468-0106

I authorize the above organization the receipt of PHI from the individual/ organization listed below:

Name:_____

Address: _____

_____

_____

Phone: _____

Fax: _____

The purpose and need for such disclosure is as follows:

( ) Diagnosis	( ) Treatment Summary	( ) Treatment Progress
( ) Attendance	( ) Intake/ Assessment	( ) Prognosis
( ) Disability Forms	( ) Emergency Records	

( ) School Records – Specify _____

_____

Other – Specify _____

_____

The authorizing person must place their initials next to the purpose/need for such disclosure:

( ) Provision of Behavioral Health Services		( ) Billing Purposes
( ) Social Security	( ) Emergency Contact	( ) Family Involvement
( ) Worker's Compensation	( ) Disability Certification	( ) Attorney Inquiry

( ) Other – Specify _____

_____

I understand that my record may contain sensitive information, including alcohol and drug abuse records protected under 42 code of Federal Regulations, Part 2, if any; psychological services records, if any, including communications made by me to a psychiatrist, social worker, or psychologist; and information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, ARC.

I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization. I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest to a claim under my policy.

This authorization will expire (insert date): _____

Phone: (734) 582-4294
Fax: (734) 468-0106

If I fail to specify an expiration date, this authorization will expire one year from the date that I sign the authorization.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the information may not be protected by federal privacy laws or regulations.
I understand that authorizing the use or disclosure of this information is voluntary. I do not need to sign this form in order to receive mental health counseling services.

_____

Signature of client or legal representative Date

_____

Please print name

_____

Relationship to client

_____

Witness Date

Date records sent: _____ Initials: _____

Notes: _____

_____

_____

_____