SHER PSYCHIATRY, PLLC
41400 DEQUINDRE ROAD SUITE 107
STERLING HEIGHTS, MI 48314
PHONE: 586-466-5911 FAX: 586-466-5921

REQUEST/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize Sher Psychiatry to (please mark one):

_____ Release _____ Obtain _____ Exchange

Information contained in my medical record with the following person or organization:

Name: _____ Organization: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Specified information to be released including psychiatric/psychological/drug abuse treatment records and Acquired Immunodeficiency Syndrome, AIDS Related Complex and Human Immunodeficiency Virus (AIDS, ARC, HIV+) information, if applicable, protected under regulations in Code 42 of the Federal Regulations, Part 2 and Federal HIPPA regulations.

Type of information to be disclosed:

_____ Diagnosis	_____ Dates of service	_____ Prognosis
_____ Psychiatric Evaluation	_____ Medication Reviews	_____ Treatment Plan
_____ Medication Log	_____ Insurance/Financial	_____ Discharge Summary

_____ Other (please specify): _____

Purpose for disclosure:

_____ Continuity of Care	_____ Assessment of Patient	_____ Employer Request
_____ Legal Involvement	_____ Disability Benefits	_____ School Request
_____ Insurance Benefits	_____ Payment	_____ Discharge Summary

_____ Other (please specify): _____

Without expressed revocation, this consent expires: _____
If no specifications, this consent will automatically expire one year from the date of the client's signature

1. This consent may be revoked at any time. A revocation will not affect any action taken in reliance on the authorization prior to the revocation.
2. This authorization is valid only for the information, agencies, and person cited above and for the purpose for which it was obtained.
3. Any further disclosure of this information is not permitted without specific authorization from the client to do so.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Witness: _____ Date: _____