Authorization for the Release of Information

I, _____ hereby authorize Tree of Life Counseling Services, LCC, its Director or designee, or Medical Records Department, to release information contained in my records, including alcohol and drug abuse records, protected under the regulations of Federal Regulations, Part 2, if any, psychological services, if any, social service services records, if any, including communications made by me to a counselor, and any information regarding serious communicable diseases and infections as defined by MCLA 333.5131 which includes venereal diseases, tuberculosis, HIV, AIDS or ARC, if any, to the individual organization listed. Note: 42 Code of Federal Regulations, Part 2, prohibits redisclosure of alcohol and drug abuse records protected under the regulation.

Name of person(s) or organization(s) to whom disclosure is to be made (e.g., insurance, family members, courts):

_____

Specific type of information to be disclosed:

- ☐ Diagnosis
- ☐ Attendance
- ☐ Progress Review
- ☐ Prognosis
- ☐ Billing Purposes
- ☐ Discharge Summary
- ☐ Recommendations
- ☐ Provisions of Behavioral Treatment
- ☐ Continuity of Treatment
- ☐ Significant Other Involvement
- ☐ Other:

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature (if appropriate): _____

DOB: _____ Last 4 Numbers of Social Security: _____

I would like a copy of this release for my records.

Witnessed by: _____ Date Witnessed: _____

Witness Signature: _____

This consent can be revoked at any time by providing written notification except to the extent that information has already been released. Without expressed revocation, this consent expires in one year from the date signed unless otherwise indicated below. Any consent for release of information or records shall end when the purpose for release has been achieved.

Revoked Date: _____ Signature: _____