PERSPECTIVES COUNSELING CENTERS

- 888 W. Big Beaver Rd, Suite 1450, Troy MI 48084
- 4151 17 Mile Rd, Suite D, Sterling Heights MI 48310
- 23965 Novi Rd, Suite 130, Novi MI 48310
- 3694 Clarkston Rd, Suite D, Clarkston MI 48348
- 705 S. Main Street, Suite 280, Plymouth MI 48170
- 1000 W University Dr, Suite 302, Rochester Hills, MI 48307

REQUEST/AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Client Name_____ Birth date_____

I hereby authorize Perspectives Counseling Centers to_____Release,_____Obtain, or_____Exchange information contained in my medical record with the following person or organization (please include address if information is to be released):

1. Name of person or organization, to whom disclosure/request is to be made:

   Name_____

   Organization Name Records Deposition Service

   Street Address 27355 W. 11 Mile Rd.

   City Southfield State MI Zip Code 48033

   Phone (248) 357-3330 email: requests@recdep.com

Specific 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 the regulations in Code 42 of the Federal Regulations, Part 2 and Federal HIPPA regulations.

2. Specify type of information to be disclosed:

☐	Diagnosis	☐	Comprehensive Assessment (intake)
☐	Attendance	☐	Treatment Plan and Reviews
☐	Appointments	☐	Psychological Testing
☐	Billing and Payment Information	☐	Discharge Summary
☐	Prognosis	☐	Psychiatric Evaluation

3. Purpose and need for such disclosure:

☐	Continuation of Care	☐	Multi-Disciplinary Treatment	☐	Third Party Reimbursement
☐	Employment/Job Stability	☒	Legal Involvement	☐	Scheduling Appointments
☐	School Involvement	☐	Disability Benefits	☐	Consultation
☐	Insurance/Gatekeeper	☐	Aftercare Planning	☐	
☐	Family Involvement	☐	Other	☐	

4. Without expressed revocation, this consent expires: _____
If no specifications, this consent will automatically expire upon 90 days post discharge.

This consent is subject to revocation in writing at any time. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration of no longer than that reasonably necessary to achieve the purpose for which it is given. Other limitations on your right to revoke this authorization may be found in the provider's Notice of Privacy Practices. This authorization is valid only for the information, agencies and person cited above and for the purpose for which it was obtained. ANY FURTHER DISCLOSURE OF THIS INFORMATION IS NOT PERMITTED WITHOUT SPECIFIC AUTHORIZATION FROM THE CLIENT TO DO SO.

5. I hereby authorize the disclosure of my protected health information as specified above.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client is a minor) Date

_____ _____
Witness Signature Date