LIFESPAN CLINICAL SERVICES
18316 Middlebelt Rd.
Livonia, MI 48152

AUTHORIZATION AND CONSENT TO DISCLOSE INFORMATION

Client Name: _____ DOB: _____

Address: _____ S.S.#: _____

I, _____, authorize Lifespan Clinical Services

to disclose information in my _____ records to:

RECORDS DEPOSITION SERVICE, P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P. 248-357-3330 F. 248-357-3337

(complete name and address of facility)

1. Specific information to be disclosed: (**you may not request (all) or (entire) TX record you must specify)**
You must sign your initials next to each item to be disclosed

_____ **Assessment**	_____ **Treatment Plan/IPOS**	_____ **Psychiatric Evaluation**
_____ Fee Agreement	_____ Treatment Plan Review/IPOS Review	
_____ Progress Notes	_____ History Form	_____ Psychological Test Report
_____ Contact Notes	_____ **Medication Information**	_____ **Recent Diagnosis**
_____ Attendance	_____ **Medication Consent(s)**	_____ **Level of Care**
_____ **Discharge Summary**	_____ **Progress in Treatment**	
_____		_____ Other

This consent authorizes Lifespan Clinical Services to disclose information contained in the client's records, including alcohol and substance abuse records, if any; Social Services records, if any; HIV, AIDS, ARC records, if any.

2. Purpose or need for disclosure : **You must sign your initials next to each purpose that applies.**

_____ Provision of Mental Health Services	_____ Billing Purposes	_____ Continuity of Treatment
_____ Family Involvement	_____ Aftercare Planning	_____ **Coordination of Care**
_____		_____ Other.

If release to self, complete statement below.

I, _____, accept full responsibility for confidential records received from Lifespan Clinical Services.

_____.
Signature

I understand that my treatment records are protected under the federal regulations governing confidentiality of patient records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act of 1996 ('HIPPA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that any notice to revoke this consent must be in writing and that in any event, this consent expires automatically as follows:

Six months from date of signature or _____

(discharged from treatment, specification of the date, event, or condition upon which this consent expires)

_____

Client/Parent/Guardian Signature Date

rev. 8/27/04 ssm Author. to disclose Info.