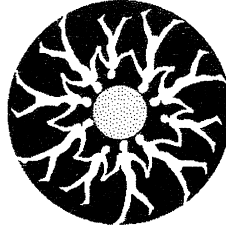


# John F. Kennedy Behavioral Health Center

Delores Wilson Esq.  
Chairperson  
Board of Directors



Jo Williamson  
President/CEO

## Release of Information

I \_\_\_\_\_  
Print Name DOB \_\_\_\_\_

Print Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

give my permission to **(JFK)** to release the following specific information on me or my child.  
Circle One

\_\_\_\_\_  
Print child's name if under 14 years of age (MH only)

### Type of information to be released: Client must initial all that applies

\_\_\_\_\_ Psychiatric Evaluation/CBE/CBR    \_\_\_\_\_ Therapist Notes    \_\_\_\_\_ Doctor Notes  
\_\_\_\_\_ Medication Order Sheets    \_\_\_\_\_ Treatment Plans    \_\_\_\_\_ Intake Documentation  
\_\_\_\_\_ Discharge Documentation     Other (Specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Requested dates of treatment \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_

To the following: RECORDS DEPOSITION SERVICE, INC.

Print Name of Institution or Intended Person(s)

P: 248-357-3330

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

F: 248-357-3337

Print Address

The purpose of this authorization is LITIGATION / DISCOVERY BEFORE TRIAL  
Specify

**Note:** The purpose for disclosure or release is at the request of the Individual.

This consent shall be in effect from \_\_\_\_\_ to \_\_\_\_\_  
Date Date (Not more than 1 yr.)

### Client must initial the following:

\_\_\_\_\_ I (we) understand that this authorization is voluntary and that my treatment, payment for services, enrollment, or eligibility for benefits will not be affected if I do not sign this form.

\_\_\_\_\_ I will be told the name, address and the date when the information will be sent.

\_\_\_\_\_ I have the right to revoke consent at any time by written or verbal request to my therapist, case manager or doctor unless the disclosure has already been made. If a verbal request is made, the staff is responsible to put such request in writing.

\_\_\_\_\_ Within 5 days of the date of this authorization, I have the right to inspect all information to be released. After such time, my information will be automatically sent out.

\_\_\_\_\_ I understand that information from sources other than JFK will not be released.

\_\_\_\_\_ I understand that there is a potential for the released information to be redisclosed by the recipient.

\_\_\_\_\_ I consent to release and disclosure of my confidential Drug & Alcohol related information.

\_\_\_\_\_ I have accepted / declined a copy of this form.  
Circle One

**Please initial or mark N/A if not applicable:**

\_\_\_\_\_ I consent to disclosure of my treatment summary if any, in relation to my drug, alcohol abuse or dependency to medical personnel, government officials, judges and probation/parole officers and 3<sup>rd</sup> party payors. This is pursuant to 4 PA Code § 255.5.

\_\_\_\_\_ I consent to release and disclosure of my Confidential HIV - related information.

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian of Child under 14 years of age (MH only)

\_\_\_\_\_  
Signature of Parent/Guardian of Child under 14 years of age (MH only)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Witness Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Unit/Title

This information complies and remains in accordance with the Health Insurance Portability and Accountability Act of 1996.