AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
NORTHEAST GUIDANCE CENTER

12800 E. Warren • Detroit, Michigan 48215 • (313) 824-8000

Client's Name ______________________ Address ______________________

City/State/Zip: ______________________ D.O.B. (mm/dd/yy): __________ Case# __________

Soc. Sec.#: ______________________ Request Date: ______ / ______ / ______

I, ______________________ the below named person, authorized the release of the following protected health information (which may include storage or fax transmission of records), including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; and social services records; if any; including communications made by me to a social worker or psychologist, to the individuals or organizations listed below, only under conditions listed below.

I Authorize:	The protected health information may be disclosed to:
Name Northeast Guidance Center	Name RECORDS DEPOSITION SERVICE, INC.
Address 12800 E. Warren Avenue	Address PO BOX 5054
City Detroit State Michigan Zip 48215	City SOUTHFIELD State MI Zip 48086-5054
	Purpose of Disclosure: PRE-TRIAL DISCOVERY
Attn.:	Attn.:

Please initial the specified information to be released as follows:
Information to be released which may be contained in my clinical and/or electronic record to include psychiatric/psychological, substance/ drug abuse treatment records and AIDS, ARC, HIV information, if applicable.

______ Psychosocial History
______ Psychiatric Evaluations/Diagnosis
______ Progress Notes
______ Psychological Evaluation
______ Academic or Educational Records
______ School Counseling Records
______ Admission Summaries
______ Discharge Summaries
______ Individual Plan of Service
______ Legal Information
______ A copy of recent physical exam
______ Laboratory Test Results
______ Nursing Assessment
______ Lithium Level
______ Health Status (including any restrictions)
______ Information related to HIV, ARC and/or AIDS condition(s)
______ Drug and alcohol abuse information
______ Permits both parties verbal communication
______ Other ______________________

The purpose and need for such disclosure is for the ongoing evaluation and treatment planning of the above named client. The authorization is valid only for the information, agency and person cited above. I understand as set forth in the "NOTICE OF PRIVACY PRACTICES", I have the right to revoke this authorization by sending written notification to the PRIVACY OFFICER. Any consent shall have duration no longer than what is reasonably necessary to achieve the purpose for which it is given. Re-disclosure of the information could be possible when deemed appropriate. This authorization expires ninety days after the client/legal guardian's date of signature. ***This information release authorization form has been prepared in compliance with title 42 of the Code of Federal Regulations, Part II; in accordance with the authority specified in Public Act 56 of 1973; and in compliance with Section 748, Act 259, 1974 "Michigan Mental Health Code;" and the Healthcare Information Portability and Accountability Act of 1996.***

______________________ Consumer/Parent/Legal Guardian's Signature

______________________ Relationship to Client

______________________ Witnessed by

______ / ______ / ______ Date

____
Privacy Officer - 12800 E. Warren, Detroit, MI 48215