DMC
DETROIT MEDICAL CENTER

☐ CHM ☐ HWH
☐ DRH ☐ KEI
☐ DSH ☐ RIM
☐ HUH ☑ SGH
☐ HVSH ☐ _____

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Patient Label

Authorization to Release Medical Information - Psychotherapy Notes Only

Patient Name_____ Date of Birth_____

Social Security #_____ Maiden/Other Name_____

Patient Address_____
Street City State Zip

Phone Number_____

I authorize SINAI GRACE HOSPITAL to release "psychotherapy notes" which he/she maintains about me which have been records as part of my treatment. Psychotherapy notes are writings (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations that he/she and I have had during a private counseling session.

Name to whom information may be released: RECORDS DEPOSITION SERVICE, INC.

P.O. BOX 5054	SOUTHFIELD	MI	48086-5054
Address	City	State	Zip

P: (248) 357-3330 F: (248) 357-3337

Area Code Telephone

The Purpose and Need for Such Disclosure:

FOR DISCOVERY BEFORE TRIAL

Please include a statement as to how the information is to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to my mental health professional as he/she may direct. While we may have already released the information based on your original authorization, we will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

These psychotherapy notes will be disclosed only as specified in this authorization. This authorization will expire 120 days from the date of the signature, or once we have completed the disclosure(s) you've requested, whichever is shorter.This information may be subject to re-disclosure by the recipient and may then no longer be protected.

_____ _____
Signature of Patient/Parent/Personal Representative Date

_____
Print Name/Relationship to Patient