evolve
Behavioral Health of Brighton

Client and Therapist: Please use this specific Release of Information with any young adults (18+) who are covered on a parent's insurance policy or whose parents, legal guardian, etc will be involved in payment on their account. This allows the Billing Dept to facilitate payment and straighten out billing/payment problems. Please send this completed form along with other initial paperwork to Billing and keep the original in the chart

Client's Address

City, State, Zip Code

Client's Date of Birth

Phone Number

☐ T O HAVE INFORMATION SENT TO

I authorize:

to disclose information contained in my medical record, including alcohol and drug abuse records, protected under Code 42 of the Federal Regulations, Part 2, (if any) mental health or physical health information, including communications made by me to a social worker, psychologist, psychiatrist, medical doctor, or primary care physician to:

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☐ I AUTHORIZE TO RELEASE THE FOLLOWING TO THE PARTY LISTED BELOW

I authorize to release information contained in my medical records including alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, (if any), mental health records, psychiatric records, including communications made be me to a social worker, psychologist, psychiatrist, to the individuals or organizations listed below, only under the conditions listed below:

Parent, Legal Guardian, Insurance Holder or Responsible Party

Address

Suite

City, State, Zip Code

INFORMATION TO BE RELEASED & REASON FOR DISCLOSURE:

Must Speci fyat least one: Or Release NOT Valid ↔ Must Speci fyat least one: Or Release NOT Valid

- ☐ All Therapy Chart Forms
- ☐ Initial Assessment, and Discharge Summary Only
- ☐ Psychiatric Chart Only
- ☐ Both Psychiatric Chart & Therapy Chart
- ☐ Other:(specify)

- ☐ Phone Consultation with Provider Listed
- ☐ Change of Provider
- ☐ Social Security / Disability Certification
- ☐ Attorney Inquiry / Legal Matter
- ☐ Other:(specify)

REVOCATION CLAUSE / SIGNATURE

This consent may be revoked at any time. not responsible for information released prior to revocation. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Ann Arbor Consultation Services.

Signature of Client, Parent, or Legal Representative

Witnessed By:

Date:

Date:

Relationship: ☐ Client ☐ Parent ☐ Legal Representative = (must include copy of guardianship papers or a Power of Attorney)

Revised 10/2007