Release of Information

I, _____ (*insert name of Patient/Client*), whose date of birth is _____ hereby authorize Janelle Staviski, LMSW to disclose to and/or obtain information from :

Name of Person or Organization: _____

Address: _____

Phone number: _____

Description of Information to be Disclosed:

(*Patient/Client should initial each item to be disclosed*)

____ Assessment

____ Diagnosis

____ Treatment Plan or Summary

____ Treatment Plan Update

____ Presence/ Participation in Treatment

____ Other: _____

____ Educational Information

____ Discharge / Transfer Summary

____ Progress in Treatment

____ Demographic Information

____ Psychotherapy Notes *

*(* Cannot be combined with any other disclosure)*

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Janelle Staviski, LMSW at 11 Carleton Road East, Hillsdale MI 49242. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

This authorization is valid for 90 days, or on _____, whichever is earlier.

Conditions

I further understand that Janelle Staviski, LMSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided]

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

I will be given a copy of this authorization for my records.

_____
Patient/Client Name

_____ _____
Patient/Client Signature Date

_____ _____
Guardian/Representative's Signature Date

Janelle Staviski
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