LAKES
psychiatric
center

LAKES PSYCHIATRIC CENTER

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name:
Birth Date:
Other Names Used in Treatment:

I authorize the disclosure of records about me
(or my minor child) between:

Name: Lakes Psychiatric Center
Address: 2300 Haggerty Road Suite 2160
City, State, Zip: West Bloomfield, MI 48323
Attention:
Phone:248-859-2457 Fax: 248-859-2473

and

Relationship

Name:
Address:
City, State, Zip:
Attention:
Phone: Fax:

Information may include any of the following:
Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Check all that apply to person/organization listed above.)

	Identifying Information		Financial/Insurance Information		Psychiatric Med. Reviews
	Appointment Information		Lab Results		Psychological Testing
	Assessment		Physical Examination		Thank You Letter
	Dates and/or Completion of Tx		Progress Notes		Treatment Plans
	Discharge Summary		Progress Report		Urine Drug Screens
	Emergency Contact		Psychiatric Evaluation		

Purpose and need for such disclosure: (Check all that apply to person/organization listed above.)

	After Care Planning		Educational Planning/Placement		Payment
	Assessment of Patient		Employer Request/Job Stability		Pre-Employment Screening
	Continuity Care		Family Involvement		Referral for Services
	Disability Benefits		Insurance Benefits		Social Security Benefits
	Drivers License Appeal		Legal Services/Compliance		Treatment Planning
	Other				Worker Comp. Benefits

Revocation of authorization: *This Authorization may be revoked by me at any time by my written notice to the above named individual or organization, except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.*

Without expressed revocation, this consent expires for the following reason(s), whichever is later (check one box):

☐ *Date: (One year from discharge unless otherwise specified)___*
Event: ———————————————————————
Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

Redisclosure: *While Lakes Psychiatric Center does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.*

Patient Signature_____ Date_____
Parent/Legal Guardian Representative_____ Date_____
Witnessed by_____ Date_____