LAKES CENTER
mental health network

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:

Lakes Center
Attention:
2300 Haggerty Rd, Suite 2160
West Bloomfield, MI 48323
Phone: 248-859-2457
Fax: 248-859-2473

AND

Physician / Organization:
Attention:
Address:
City, State, Zip:
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
- ☐ Appointment Information
- ☐ Assessment
- ☐ Dates and/or Completion of Tx
- ☐ Discharge Summary
- ☐ Emergency Contact
- ☐ Financial/Insurance Information
- ☐ Lab Results
- ☐ Physical Examination
- ☐ Progress Notes
- ☐ Progress Report
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Med. Reviews
- ☐ Psychological Testing
- ☐ Thank You Letter
- ☐ Treatment Plans
- ☐ Urine Drug Screens
- ☐ Other: _____ _____

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

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

Revocation of Authorization

This Authorization may be revoked by me at any time by my written notice to the named individual or organization (listed above), 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.

Rediscloure: While Lakes 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 Signature Date