DONARSKI CENTER *for* MENTAL HEALTH COUNSELING

Authorization for Release of Patient Health Information

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From/To:	From/To:
Institution _____	Donarski Center for Mental Health Counseling
Person _____	
Street Address _____	830 Pleasant Street, Suite 201
City/State/Zipcode _____	Saint Joseph, MI 49085
Phone _____	Phone: 269-982-3832
Email _____	Email:
Fax: _____	Fax: 269-281-0351

I authorize the release of information covering the period(s) of healthcare from
From (date): _____ To (date): _____

The type of information to be used or disclosed is as follows:

□ History & Initial evaluation	□ Progress notes	□ Abstract (summary of health history)
□ Consultation reports	□ Treatment plans	□ Psychological Test Results
□ School records/Behavioral Reports	□ Verbal only (specify)	□ Manage appointments

□ Other (please specify) _____

These highly confidential items must be checked off to be included in the use/disclosure of other health information:
□ Drug/alcohol diagnosis,treatment, and/or referral information *(patients 12 or over must authorize this release)*
□ Information about sexual assault/abuse
□ Information about child abuse and neglect

This information for which I am authorizing disclosure will be used for the following purpose:
□ My personal use (there is a fee for personal use copies)
□ Sharing with other health care providers (No charge if sent directly to the provider. Address must be provided as recipient above)
□ Other (please specify) _____

Signature: _____ (Patient Parent Guardian)

Date: _____ If not otherwise specified, this release will expire in One Year

Witness Signature: _____ Date: _____