



**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:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> History & Initial evaluation      | <input type="checkbox"/> Progress notes        | <input type="checkbox"/> Abstract (summary of health history) |
| <input type="checkbox"/> Consultation reports              | <input type="checkbox"/> Treatment plans       | <input type="checkbox"/> Psychological Test Results           |
| <input type="checkbox"/> School records/Behavioral Reports | <input type="checkbox"/> Verbal only (specify) | <input type="checkbox"/> Manage appointments                  |
| <input type="checkbox"/> 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: \_\_\_\_\_