CLARKSTON FAMILY THERAPISTS, LLC

5639 Sashabaw Road
Clarkston, MI 48346
(248) 922-9077

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This is an authorization to release information from the records of:

_____ _____
Full Legal Name Date of Birth

_____
Address

Individual/Organization to release to:

Name:_____

Address:_____

Phone/Fax_____

Specific Information:

___ All
___Treatment Summary/Progress
___ Substance Abuse History/Treatment
___ Psychological Testing
Other (specify)_____

This authorization includes alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any psychological service records, if any social services records, if any; psychiatric records, if any; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immunodeficiency Syndrome (AIDS), ARC (AIDS Related Complex), if any; and records of communicable disease, if any; to the individuals or organizations and for the conditions listed above.

Permission:

_____
Recipient/Parent/Guardian Date

This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given shall have a duration no longer than 6 months or until the end of the current treatment period.

01/23