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Licensed Psychologists

## Request/Authorization for Release of Information

200 Diversion Street, Suite 150
Rochester Hills, MI 48307

Phone / Fax
248-453-5355

**Patient's Name**: _____ Date of Birth: _____

Patient's Address: _____

**To release** to: _____

Address: _____

**To receive from**: _____

Address: _____

The following information

- ❑ Entire record
- ❑ Evaluation results
- ❑ Treatment notes and treatment plan
- ❑ Other
  (Describe)_____

In the following formats

- ❑ Verbal
- ❑ Written
- ❑ Fax
- ❑ Other
  (Describe)_____

In order to

- ❑ Assist with treatment planning
- ❑ Document a need for services
- ❑ Support an application for
  _____
- ❑ Other:
  _____

The consent for release of information shall terminate on _____
A photocopy of this release shall carry the same force as the original. I understand that I have the right to revoke this consent upon notification of the releasing provider.

_____ _____

Signature / Relationship to Patient
Self Parent Legal Guardian

Signature of witness

Date: _____ Date: _____