SOUTHFIELD MENTAL HEALTH ASSOCIATES, P.C.
17320 W. 12 Mile Road, Suite 101
Southfield, MI 48076
Telephone: (248) 557-4667
Fax: (248) 557-4697

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name & Address_____

_____

_____

Date of Birth_____

I, _____, hereby request and authorize

___ Southfield Mental Health Associates, P.C.
___ Other (Name and Address)_____

_____

to release to

___ Southfield Mental Health Associates, P.C. (Attention to)_____
___ Other (Name and Address)_____

_____

the following items

___ Entire Medical Record
___ Evaluation (Medical, Psychiatric)_____
___ School Record
___ Other (Describe)_____

in the following formats

___ Verbal
___ Written
___ Fax
___Other (Describe)_____

in order to

___ Facilitate evaluation/treatment.
___ Provide for continuity of service.
___ Other (Describe)_____

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This consent for release of information shall terminate _____. (If no date is specified, consent is valid for one year). If there is a charge for this service, I agree to pay it. A photocopy of this release shall carry the same force as the original. I understand that I have the right to revoke this consent by notifying SMHA or the releasing provider.

Signature_____Date_____

Relationship to Client: Self/Parent/Legal Guardian (circle)

Telephone_____

Witness_____ Date_____