Claystone Clinical Associates
2040 Raybrook SE Suite 300, Grand Rapids MI 49546
Phone (616) 949-7460 Fax (616) 949-3018

AUTHORIZATION TO RELEASE INFORMATION

I, _____ DOB: _____ Social Security # _____, hereby authorize Claystone Clinical Associates therapist/psychiatrist _____ to release/exchange information contained in my records, including mental health records protected by Michigan Public Act 290 of 1995, if any, and alcohol and drug abuse records protected under Code 42 of the Federal Regulations, Part 2, if any: medical services records, if any; psychological or mental health services records, if any; social services records, if any; including communications made by me to a physician, psychologist, social worker, or other health care provider; and information regarding communicable diseases and serious communicable diseases and infections, and defined by Michigan Department of Public Health Rules. It may also include information about behavioral or mental health services and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, Public Act 258 of 1974 and 42 CRF Part 2). Re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749, & 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations Part 2, with which this authorization complies. By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the information not protected by federal privacy rules. I have had the opportunity to have his form explained to me and have my questions answered.

Name of Person/Organization which disclosure is to be made: _____

Address: _____ Phone: _____ Fax: _____

Specific type of information to be disclosed: ____ initial assessment ____ treatment summary
____ dates of service/attendance ____ psychological testing ____neuropsychological testing
____ psychiatric evaluation ____substance abuse evaluation
Other: _____

The purpose and need for such disclosure: ____ patient request ____ continued patient care
____ attorney/legal Other: _____

Without expressed revocation, this consent expires for the specific reason(s), whichever is later;
Date: _____
____ Termination of Treatment
____ Condition: Once information is disclosed, no further information may be disclosed pursuant to this consent.
____ Change in Probation Status

_____ _____
Signature of Client (Parent or Guardian if minor child Date

_____ _____
Signature of Witness Date