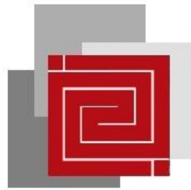

MICHIGAN MODERN PSYCHOLOGY
Therapy and Evaluations for Families and Individuals of all ages
Dr. Manuel Manrique, PhD, LP, Director
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AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

I, ____, hereby authorize Michigan Modern Psychology, its Director or his/her Designee, to release and/or obtain information contained in my patient records, including alcohol and drug abuse records protected under the regulation in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any, and social services records, if any, including communications made by me to a social worker or psychologist, to the individuals or organizations listed , only under the conditions listed below:

Client Name: ______________________________________ Date of Birth:___________________________

1. Name of individual(s) or organization to/from whom disclosure is to be made:_______________________
   Address____phone______________fax_______________
2. Specific type of information to be disclosed: (Limit information only to those areas necessary if entire case file is not necessary.)____

   ____
3. The form in which the information may be disclosed (check one or more options):
   _____ Verbal communication _____ Written report or photocopies of records
   _____ Other (explain) ____
4. The purpose and need for such disclosure: (For mental health records, include a statement as to how the information to be disclosed is pertinent to the purpose and need for such disclosure.)____

   ____

   ____
5. This consent is subject to revocation at any time except in those circumstances in which Michigan Modern Psychology has taken certain actions on the understanding that consent will continue un-revoked until the purpose for which the consent was given shall have been accomplished; however, any consent given with respect to alcohol and/or drug abuse records shall have duration of no longer than that reasonably necessary to achieve the purpose for which consent was given.
6. Without expressed revocation this consent expires on the date set forth below or for the following specified reasons: CONDITION: **Once specified information is disclosed, no further information can be disclosed pursuant to this consent.**
   or Date:__________________ or Event:____________________ or None:_________________________
7. My care or treatment will not be conditioned on signing this document.
8. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of person and health information may no longer be protected by law.

____ ______________________________
Signature of Patient, Parent, Guardian or Representative Date

____ ______________________________
Signature of Witness Date