Delta Psychological & Neurobehavioral Services
114 Tuscola Rd.; Bay City, Michigan 48708
(989) 895-0788; (989) 895-0799 (fax)

INFORMATION RELEASE AUTHORIZATION

I, ____ (Name of client), Date of birth ________________,
authorize Delta Psychological & Neurobehavioral Services to disclose to and/or obtain from:
____ the following information:

Description of Information to be Disclosed/Obtained:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Medication Management Information
_____ Other: Specify: ____________________

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify: ____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Delta Psychological & Neurobehavioral Services. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: ________________________
Or as otherwise indicated: ____

Conditions
I further understand that Delta Psychological & Neurobehavioral Services will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ______________________

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Re-disclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

Other than substance abuse treatment information, there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations.

A copy of this authorization will be given to the client or designated representative.

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Signature of Client/Parent/Guardian/Personal Representative Date

____

Signature of Staff Witness Date