Associates In Psychiatry, PLLC
Select Provider
43157 Schoenherr
Sterling Heights, Mi 48313
(586) 997-9619
586-997-9635 - Fax

Consent to Release and Receive Information

Your records, which are held in custody by Associates In Psychiatry, PLLC, are privileged and confidential. A general authorization to release psychiatric and/or psychological information is invalid according to Federal Regulation 42, CFR, Part 2, which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Your records will not be released without this waiver, except under the following circumstances: In the event of a valid emergency or upon receipt of a court order.

Patient Name:_____

Birthdate:_____ Driver License#:_____

Address:_____

Phone#:_____ e-Mail Address:_____

I authorize Associates In Psychiatry, PLLC to disclose **Date From:_____ and Date To:_____**

Release to:

Name: _____

Address:_____

Phone#:_____ Fax#:_____

The following information for:

- ☐ Psychiatric/Psychological Evaluation Summary*
- ☐ Diagnostic Evaluation Summary*
- ☐ Discharge Summary*
- ☐ Summary of Treatment Received*
- ☐ Other:*_____

***To include any substance abuse information.**

Purpose or need for the information:_____

This consent will expire upon satisfaction of the need for disclosure, not to exceed 90 days after the date signed, unless otherwise specified. I may revoke this authorization at any time providing I notify Associates In Psychiatry, PLLC in writing to that effect. However, such revocation will have no effect on any action previously taken.

A. **Upon satisfaction of the need for disclosure, not to exceed 90 days after date signed.**
B. **90 days after termination of treatment**

Patient Signature:_____ **Date**:_____

Parent/Guardian/POA Signature:_____ Date:_____

Select _____ **Date**:_____