Drew Schafer, MA, LLP | (734) 778-2467 | DSchafer@SchaferConsultingLLC.com
808 West Lake Lansing Road, Suite 200• East Lansing, MI 48823

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

As the client who is the subject of the personal health information, I authorize Schafer Consulting, LLC to disclose and/or obtain information from:

NAME OF PERSON/ORGANIZATION INFORMATION IS TO BE RELEASED FROM

STREET ADDRESS

CITY STATE ZIP

( ) ( )

PHONE FAX

Description of information to be disclosed (please initial next to each item you wish be disclosed):

____ Assessment	____ Continuing Care Plan	____ Psychological Evaluation
____ Diagnosis	____ Progress in Treatment	____ Discharge/Transfer Summary
____ Treatment Plan	____ Demographic Information	____ Presence/Participation in Therapy
____ Psychotherapy	____ Financial Balances	____ Dates and Appointment Times

The purpose of this disclosure of information is to improve assessment and treatment planning, sharing information relevant to treatment and, when appropriate, to coordinate care with other medical providers.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notice to my provider. I further understand that a revocation of the authorization is not effective to the extent that actions have been taken in reliance on this authorization. Unless revoked earlier, this authorization expires 365 days from the date of signature.

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

I understand there is the potential that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPPA privacy regulations, unless a state law applies that is more strict than HIPPA and provides additional privacy protections.

A copy of this authorization will be provided to you upon request.

PRINT NAME OF CLIENT DATE OF BIRTH

SIGNATURE OF CLIENT DATE

SIGNATURE OF PARENT / GUARDIAN DATE

SIGNATURE OF WITNESS DATE