WEST MICHIGAN PSYCHOLOGICAL SERVICES

259 Hoover, Suite 140
Holland, Michigan 49423

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Name: _____ Birthdate: _____

RECORDS AND INFORMATION MAY BE RELEASED AND EXCHANGED BETWEEN:

_____
Person or Entity to Recieve the Information Phone

_____
Address

_____
City State Zip Code

_____
Health Care Provider/ Place of Treatment Phone

_____
Address

_____
City State Zip Code

INFORMATION AUTHORIZED FOR RELEASE: (please check all that apply)

- ☐ History and Physical
- ☐ Immunization Records
- ☐ Discharge Summary
- ☐ Mental Health Treatment Information
- ☐ Clinic Notes
- ☐ Social Work Notes
- ☐ Records Related to the Specific Problems of _____

PURPOSE OF DISCLOSURE: Continued Patient Care and Treatment

CONSENT:

I understand that my records are protected under federal and state laws and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may include psychiatric, psychological and social service records (including communications made to a social worker, psychiatrist or psychologist indicated in my records), evaluation and treatment for physical, mental and/or emotional illness, drug and alcohol abuse information, and information about communicable diseases and serious communicable infections which include venereal disease, tuberculosis, hepatitis, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and ARC (AIDS Related Complex).

I understand that authorizing the disclosure of this health information is voluntary. I also understand that once the above information is disclosed by the recipient, it may be re-disclosed and the information may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will be covered by the Family Educational Rights and Privacy Act which regulates re-disclosure of the information by school districts.

This consent is valid for twelve (12) months from the date signed, but may be revoked by me to the extent action has already been taken in reliance upon this authorization, at any time by written revocation. This information released is for the specific purpose stated above and may not be provided in whole or any part to any other agency or person.

_____
Signature of Parent or Guardian Date

_____
Witness Date