Psychiatric Services of Grosse Pointe

131 Kercheval Avenue Suite 390 **Grosse Pointe Farms, MI 48236** **Office 313-885-6400**

CONSENT TO RELEASE OR RECEIVE INFORMATION

Your records which are held in custody by Psychiatric Services of Grosse Pointe, PLLC (PSGP), are privileged and confidential. A general medical authorization to release psychiatric and/or psychological information is invalid according to Federal Regulation, 42 CFR Part 2. Your records will not be released without this waiver, or one that complies with office policy, except under the following circumstances: in the event of a valid court order or an emergency.

Patient Name: _____

Birthdate: _____ **SSN**: _____

I authorize Psychiatric Services of Grosse Pointe, PLLC to (circle one preference only):
Release information to:

_____

Receive information from:

_____

The following information:

____ Psychiatric/Psychological Evaluation*
____ Progress Notes * ____ All dates of services; or From _____ To _____
____ Entire Chart (to include all progress notes, medication calls, medication logs, etc.)*
____ Laboratory results
____ Other* _____

*To include any substance abuse information and psychiatric records

Purpose or need for information: _____

This consent will expire upon satisfaction of the need for disclosure, unless otherwise specified. I may revoke this authorization at any time provided written notice to PSGP. However, such revocation will have no effect on any action previously taken. I understand that once the specified information herein has been disclosed to the recipient, that entity and or recipient may re-disclose the information received and said information may no longer be protected by the Federal Privacy Laws. We will not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed or not. A copy of this signed authorization may be obtained upon request.

A. Upon satisfaction of the need for disclosure, this authorization will expire one year from date signed.

Patient's Signature: _____ **Date:** _____

Consent of Legal Guardian or Personal Representative is necessary if Patient is unable to sign. Proof of such will be required.

Signature of Guardian, Parent, or Personal Representative: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____ Date: _____