25509 Kelly Rd, Ste A. Roseville, MI 48066 Office 586-252-2616

CONSENT TO RELEASE OR RECETVE INFORMATION

Your records which are held in custody by PSGP Psychiatric Clinicians, PLLC., 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: ________________________ **Social Security Number:** ______________________________

I authorize PSGP Psychiatric Clinicians, PLLC.: (circle one preference only)

Release to: ____

____

Receive from: ____

____

The following information:

Psychiatric/Psychological Evaluation*

Progress Notes* ________All dates of service; or From _______________ To _______________

Entire Chart (to include all progress notes, medication calls, consents for meds, medication log)*

Other*____

To include any substance abuse information and psychiatric records

Purpose or need for the information: ____

This consent will expire upon satisfaction of the need for disclosure, unless otherwise specified. I may revoke this authorization at any time provided I notify Psychiatric Services of Grosse Pointe, PLLC., in writing to that effect. 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.

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 Client is unable to sign. Proof of such will be required.

Signature of Guardian, Parent, or Personal Representative: _____________________________________

Relationship to Patient: ____Date: ___________________

Witness Signature: ____Date: __________________