



151 North Ave., • Battle Creek, MI 49017-3467 • (616) 968-2811 • Fax (616) 968-2651  
 \_\_\_\_\_

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

RE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
*Name of Client*

I, the undersigned, hereby authorize \_\_\_\_\_  
*Name and Address of Sending Agency/Person*

to release or exchange information to \_\_\_\_\_  
*Name and Address of Sending Agency/Person*

*The following information from my medical record may be disclosed (check each applicable category):*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Admission Summary                                | <input type="checkbox"/> Psychological Testing/Evaluation & Recommendations | <input type="checkbox"/> Psychiatric Evaluation                           |
| <input type="checkbox"/> Chemical Dependency Assessment & Recommendations | <input type="checkbox"/> Intake (Staffing) Summary                          | <input type="checkbox"/> Treatment Plan                                   |
| <input type="checkbox"/> Attendance                                       | <input type="checkbox"/> Communication Regarding Progress in Treatment      | <input type="checkbox"/> Motivation & Prognosis                           |
| <input type="checkbox"/> Discharge Summary (Including type and date)      | <input type="checkbox"/> Aftercare Plan                                     | <input type="checkbox"/> Medical/Health Records (Including Physical Exam) |
| <input type="checkbox"/> School Records                                   | <input type="checkbox"/> Legal Charges/History                              | <input type="checkbox"/> Other Reports & Information                      |
|   |   | Specify: _____  |

*The above information is necessary for the following purposes (check each applicable category):*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diagnosis and Treatment              | <input type="checkbox"/> Further Evaluation          | <input type="checkbox"/> Follow-up Treatment/Continuation of Care      |
| <input type="checkbox"/> Family/Significant Other Involvement | <input type="checkbox"/> Referral Source Feedback    | <input type="checkbox"/> Coordination of Care with Physician           |
| <input type="checkbox"/> Family Reunification                 | <input type="checkbox"/> School/Educational Planning | <input type="checkbox"/> Determine Eligibility for Disability Benefits |
| <input type="checkbox"/> Social Services Involvement          | <input type="checkbox"/> Legal Involvement/Follow-up | <input type="checkbox"/> Insurance Payment/Investigation               |
| <input type="checkbox"/> Custody/Visitation Evaluation        | <input type="checkbox"/> Other – Specify: _____      |  |

I understand that my records are protected by Federal Law (42 CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it (i.e. information already disclosed) and in any event this consent expires automatically as described below. However, any consent given under Subpart C, Federal Register, volume 40 –number 147, July 1, 1975, shall have a duration no longer than reasonably necessary to effectuate the purpose for which it is given. My signature also means that I have read this form and/or have had it read to me and explained in language that I can understand.

Specific date, event, or condition upon which this consent expires unless previously revoked by me: \_\_\_\_\_

Executed on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

_____ <i>Signature of Client</i>	_____ <i>Date</i>	_____ <i>Signature of Witness</i>	_____ <i>Date</i>
_____ <i>Signature of Client</i>	_____ <i>Date</i>	_____ <i>Signature of Witness</i>	_____ <i>Date</i>



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 \_\_\_\_\_

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

RE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
*Name of Client*

I, the undersigned, hereby authorize PSYCHOLOGICAL CONSULTANTS OF MICHIGAN, P.C.  
*Name and Address of Sending Agency/Person*

to release or exchange information to Doctor  
*Name and Address of Sending Agency/Person*

*The following information from my medical record may be disclosed (check each applicable category):*

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> Admission Summary                                | <input checked="" type="checkbox"/> Psychological Testing/Evaluation & Recommendations | <input checked="" type="checkbox"/> Psychiatric Evaluation                           |
| <input checked="" type="checkbox"/> Chemical Dependency Assessment & Recommendations | <input checked="" type="checkbox"/> Intake (Staffing) Summary                          | <input checked="" type="checkbox"/> Treatment Plan                                   |
| <input checked="" type="checkbox"/> Attendance                                       | <input checked="" type="checkbox"/> Communication Regarding Progress in Treatment      | <input checked="" type="checkbox"/> Motivation & Prognosis                           |
| <input checked="" type="checkbox"/> Discharge Summary (Including type and date)      | <input checked="" type="checkbox"/> Aftercare Plan                                     | <input checked="" type="checkbox"/> Medical/Health Records (Including Physical Exam) |
| <input type="checkbox"/> School Records  | <input type="checkbox"/> Legal Charges/History   | <input type="checkbox"/> Other Reports & Information                                 |
|  |  | Specify: _____   |

*The above information is necessary for the following purposes (check each applicable category):*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diagnosis and Treatment              | <input type="checkbox"/> Further Evaluation          | <input type="checkbox"/> Follow-up Treatment/Continuation of Care       |
| <input type="checkbox"/> Family/Significant Other Involvement | <input type="checkbox"/> Referral Source Feedback    | <input checked="" type="checkbox"/> Coordination of Care with Physician |
| <input type="checkbox"/> Family Reunification                 | <input type="checkbox"/> School/Educational Planning | <input type="checkbox"/> Determine Eligibility for Disability Benefits  |
| <input type="checkbox"/> Social Services Involvement          | <input type="checkbox"/> Legal Involvement/Follow-up | <input type="checkbox"/> Insurance Payment/Investigation                |
| <input type="checkbox"/> Custody/Visitation Evaluation        | <input type="checkbox"/> Other – Specify: _____      |   |

I understand that my records are protected by Federal Law (42 CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it (i.e. information already disclosed) and in any event this consent expires automatically as described below. However, any consent given under Subpart C, Federal Register, volume 40 –number 147, July 1, 1975, shall have a duration no longer than reasonably necessary to effectuate the purpose for which it is given. My signature also means that I have read this form and/or have had it read to me and explained in language that I can understand.

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Executed on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

_____ <i>Signature of Client</i>	_____ <i>Date</i>	_____ <i>Signature of Witness</i>	_____ <i>Date</i>
_____ <i>Signature of Client</i>	_____ <i>Date</i>	_____ <i>Signature of Witness</i>	_____ <i>Date</i>

PSYCHOLOGICAL CONSULTANTS OF MICHIGAN, P.C.  
**ADULT DATA SHEET**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
*(Maiden)*

If couple, Spouse/Partner's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street* *City* *State* *Zip*

Phone ~ Work: ( ) \_\_\_\_\_ Home: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex: \_\_\_\_\_ Religion: \_\_\_\_\_ Social Security No. \_\_\_\_--\_\_\_\_--\_\_\_\_ Drivers License No. \_\_\_\_\_

Ethnic Background: White  Black  Hispanic  Asian  Native American  Other  \_\_\_\_\_

EDUCATION: Highest Degree/Diploma: \_\_\_\_\_ GED  School: \_\_\_\_\_

Highest Grade: \_\_\_\_\_ Last date attended: \_\_\_\_\_

**EMPLOYMENT:**

Occupation: \_\_\_\_\_ Unemployed  Disabled

Present Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_ Position: \_\_\_\_\_

Previous Employers: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_ Position: \_\_\_\_\_

\_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_ Position: \_\_\_\_\_

Client Living With: \_\_\_\_\_ Relationship(s): \_\_\_\_\_

Marital Status: Single  Married  Divorced  Separated  Widowed

Date(s) Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_

Date(s) Previous Marriage(s) (if any): \_\_\_\_\_ Date(s) Previous Divorces (if any): \_\_\_\_\_

Self: \_\_\_\_\_ Self: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_ Spouse/Partner: \_\_\_\_\_

<b>Family Composition:</b>						
<i>Relationship</i>	<i>Name</i>	<i>Age</i>	<i>Education</i>	<i>Place of Work/School</i>	<i>Living in Home?</i>	<i>If no, where?</i>

Client's Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, notify: Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Voluntary  Involuntary

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*THANK YOU\***