



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.

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>

PSYCHOLOGICAL CONSULTANTS OF MICHIGAN, P.C.
CHILD/ADOLESCENT DATA SHEET

Name: _____ Birthdate: _____ Age: _____

Custodial parent/guardian: _____ Phone: (Home) _____

Address: _____ Phone: (Work) _____
Street City State Zip

Joint Custodial Non-Custodial Parent (if any): _____ Parent E-mail: _____

Address: _____
Street City State Zip

Phone ~ Home: _____ Work: _____ Drivers License: _____

Sex: _____ Religion: _____ Social Security No. _____ -- _____ -- _____

Ethnic Background: White Black Hispanic Asian Native American Other _____

Current School: _____ Grade: _____ Special Education Program (Circle): E.I. L.D. E.M.I.

Principal: _____ Teacher: _____ Counselor: _____

Employment (if any): _____ Dates: _____ to _____ Position: _____

Living With: _____ Dates: _____

Custody of: _____ Relationship: _____

PARENTS: Never Married Date Married: _____ Separated: _____ Divorced/Widowed: _____

Date(s) of Divorce(s) (if any): Father: _____ / _____ / _____ Mother: _____ / _____ / _____

Additional Marriages: Father: _____ / _____ / _____ Mother: _____ / _____ / _____

Occupations: Father: _____ / _____ / _____ Mother: _____ / _____ / _____

FAMILY COMPOSITION AND RELATIONSHIPS:

<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 not, where?</i>
<i>Parent(s):</i>						

Siblings/Other Children:

Client's Physician: _____ City/State: _____ Phone: _____

In case of emergency, notify: Name: _____ Address: _____ Phone: _____

Referred By: _____ Voluntary Involuntary

Joint/Non Custodial Parent informed of referral to PCM? Yes No

Parent/Guardian's Signature: _____ Date: _____

THANK YOU