SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Release Medical Records Information

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

I authorize SPSI to release and/or obtain medical and/or mental health information contained in my records as specified below and to provide access to or provide such photocopies as may be requested of the person or organization and to the extent and nature listed below, subject to the conditions listed below.

I authorize SPSI to provide information to the following Person(s)/Organization(s)

Printed Name
Address
Telephone Number
Fax Number
Covering Date of Service Range

Place a "x" next to information to provide:

	Psychological Evaluation		Treatment Summary		Medication Review(s)
	Psychiatric Evaluation		Discharge Summary		Discharge Instructions
	Lab Work Results		Clinical Psychotherapy Note(s)		
	Other (specify)				

Identified information should be disclosed:

	Verbally		Hard Copy

Place a "x" next to purpose of disclosure:

	Employer Request		Vocational Rehabilitation		Attorney Inquiry
	Insurance Claim		Social Security		Disability Certification
	Continuation of Care		Consultation		Insurance Application
	Social Service		Worker's Comp		
	Other (specify)				

Place a "x" to authorize disclosure of records/information/notes related to:

	HIV/AIDS		Substance Abuse

I authorize SPSI to obtain information from the following Person(s)/Organization(s)

Printed Name
Address
Telephone Number
Fax Number
Covering Date of Service Range

Place a "x" next to information to provide:

	Psychological Evaluation		Treatment Summary		Medication Review(s)
	Psychiatric Evaluation		Discharge Summary		Discharge Instructions
	Lab Work Results		Clinical Psychotherapy Note(s)		
	Other (specify)				

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I authorize SPSI to obtain information from the following Person(s)/Organization(s) ***Continued***

Identified information should be disclosed:		Verbally		Hard Copy

Place a "x" next to purpose of disclosure:

	Employer Request		Vocational Rehabilitation		Attorney Inquiry
	Insurance Claim		Social Security		Disability Certification
	Continuation of Care		Consultation		Insurance Application
	Social Service		Worker's Comp		
	Other (specify)				

Place a "x" to authorize disclosure of records/information/notes related to:

	HIV/AIDS		Substance Abuse

I understand that my records are protected by Federal and State Confidentiality Laws, and cannot be further disclosed without my written authorization, unless release is required by other State or Federal regulations. I understand that there is a possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand that I may inspect or copy any information released under this authorization.

I understand this authorization will expire upon termination of services, or one year from the date of signature. I further understand that, per the Privacy Notice, I may revoke this authorization at any time by notifying Saginaw Psychological Services, Inc in writing, but that previously disclosed information would be subject to may revocation request.

Signatures Attesting to My Consent to Release of Information:

Client/Guardian Signature Date

Witness Signature Date