ASSOCIATED PSYCHOLOGISTS

19900 Ten Mile Road
St. Clair Shores, MI 48080

Telephone: (586) 776-3366
Facsimile: (586) 776-3369

I, _____ hereby authorize
(Client's Name)

_____
(Individual or Organization)

its administrator, Medical Director or designee, to release information contained in my records, including alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, if any: medical service records, if any, psychological or mental health service records, if any, social services records, if any, including communications made by me to a physician, psychologist, social worker, or other health care provider; and information regarding communicable diseases and serious communicable diseases and infections which, as defined by Michigan Department or Public Health Rules, including venereal disease (VD), tuberculosis (TB), Hepatitis B, human immunodeficiency syndrome (AIDS) and AIDS related complex (ARC), if any, to the individual(s) and/or organization(s) listed below and only under the condition(s) listed below:

Client's Birthdate: _____ Social Security Number: _____

1. Name of individual(s) and/or organization(s) to whom disclosure is to be made: _____

   _____

   Address: _____

2. Specific type of information to be disclosed: _____

   _____

3. The purpose and need for such disclosure (for mental health records, state how the information is germane to the purpose and need):

   _____

4. This consent can be revoked at any time unless the individual, organization or its staff has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given has been accomplished. However, any consent given for alcohol and/or drug abuse records shall have a duration no longer than that which is reasonably necessary to achieve the purpose for which it is given.

5. Without expressed revocation this consent expires for the following specified reason(s), whichever is later:

   [ ] Date: (60 days unless otherwise specified) _____

   [ ] Event: _____

   [ ] Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Representative Date

_____ _____
Signature of Witness Date