Viewpoint Psychology & Wellness, LLC
2075 E. West Maple Road – Suite B-208 – Commerce Township – Michigan – 48390
Phone / Fax: 248-669-9500

Authorization to Release and / Obtain Patient Information

I, _____, hereby authorize Viewpoint Psychology and Wellness, LLC, of Commerce Township, Michigan and its contracted wellness providers to release and / or obtain information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 CFR, if any, psychological services records, if any, and social services records, if any including communications made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

Birthday of Patient: _____

Name of Individual(s) or organization(s) to/from whom disclosure is to be made: _____

_____

Address of Name of Individual(s) or organization(s) to/from whom disclosure is to be made: _____

_____

Specific type of information to be disclosed (only those necessary if entire file is not): _____

_____

_____

The form in which the information may be disclosed is:

Verbal communication ☐ Written Report ☐ Photocopies of records ☐
Other ☐ _____

The purpose and need for such disclosure: _____

_____

This consent is subject to revocation at any time except in those circumstances in which the Practice has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given with respect to alcohol and / or drug abuse records shall have a duration of no longer than that reasonably necessary to achieve the purpose for which it is given.

Without expressed revocation, this consent expires on the date set forth below **or** once information is disclosed (event) **or** does not expire.

☐ Expires by Date ☐ Expires by Event ☐ No Expiration

Signature of Patient:	Date:
Signature of Parent, Guardian or Representative	Date:
Signature of Witness:	Date: