TrueNorth Christian Counseling – 50200 W. Ten Mile Rd., Novi MI, 48374 Phone(248)-374-6003

Cathy Ehlers, MA., LPC. Melissa Armbruster, MA., LLP Lynn Jarrett, MA., LPC
Vicki Van Gorder, MA., TLLP Chuck Shepard, MSW Salpi Tachian, MSW, LL

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Clients name: _____
   First Name Middle Name Last Name

2 Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

   _____
   Name (client, provider, or other)

5. Information to be released:

   - Authorization for Psychotherapy Notes ONLY (important: if this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

   - Other:

   __ Test Results
   __ Intake Evaluation
   __ Psychosocial History
   __ General Summary of Progress
   __ Other _____
   __ Treatment Recommendations
   __ Diagnostic Impressions
   __ Records Summary

6. Purpose of Disclosure: The reason I am authorizing release is:

   - My Request
   - Other (describe) _____

7. _____
   Person(s) Authorized to Make the Disclosure:
8. _____
   Person(s) Authorized to Receive the Disclosure:

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:
_____

Authorization and Signature: I authorize the release of my confidential protected health Information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Client:

_____

Signature of Personal Representative:

_____

Relationship To Client if Personal Representative:

_____

Date of signature: _____