Bay Area Counseling, LLC
3180 Racquet Club Drive Ste G Traverse City, MI 49684
Phone: 231-933-4009 Fax: 231-933-4032

Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Legal Purposes
School: _____		Other: _____

INFORMATION TO BE RELEASED OR ACCESSED: (Please circle desired records)

Diagnostic Evaluation	Consultation Report	Treatment Plans	Testing Reports
Clinical Summaries	Discharge/Death Summary	Billing Account Summary	

Other: _____

Specify name or title of the individual or the name of the organization to which the above records are to be released and the appropriate address.

TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time (See CFR §164.508(c)(2)(i-iii).

Signature: _____

Date: _____ Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient