LIFESPAN CLINICAL SERVICES
18316 Middlebelt Rd.
Livonia, MI 48152

AUTHORIZATION AND CONSENT TO DISCLOSE INFORMATION

Client Name: _____ DOB: _____

Address: _____ S.S.#: _____

I, _____, authorize Lifespan Clinical Services

to disclose information in my Mental Health records to:

CD Services, Inc. 24027 Research Drive Farmington Hills, MI 48335 PH(248)476-1700
(complete name and address of facility) FX(248)476-6600

Specific information to be disclosed: (you may not request (all) or (entire) TX record you must specify)
You must sign your initials next to each item to be disclosed

- X Assessment
- X Discharge Summary
- X Treatment Plan/IPOS
- X Medication Reviews
- _____ Other _____
- X Psychiatric Evaluation
- X Treatment Plan Review/IPOS Review
- _____ Psychological Test Report

I understand that the information to be released includes: (initial appropriate boxes)

- _____ Diagnoses and/or treatment for alcohol and/or drug abuse
- _____ HIV test results
- _____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment
- _____ Diagnoses and/or treatment relating to other communicable diseases

This authorization for disclosure is for the following purpose: (initial appropriate boxes)

- X Provision of Mental Health Services
- X Family Involvement
- _____ Other: _____
- _____ Billing Purposes
- _____ Aftercare Planning
- _____ Continuity of Treatment
- X Coordination of Care

I understand that my treatment records are protected under the federal regulations governing confidentiality of patient records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act of 1996 ('HIPPA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that any notice to revoke this consent must be in writing and that in any event, this consent expires automatically as follows:

Six months from date of signature or _____
(discharged from treatment, specification of the date, event, or condition upon which this consent expires)

X _____
Client/Parent/Guardian Signature Date

* Copy of this completed form was given to Client/Parent or Guardian

CDS JOB#_____