Grace Counseling Center
20801 Moross Rd.
Detroit, MI 48236
Phone - (313) 343-9000
Fax - (313) 343-9012

REQUEST/AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

I, _____, Date of Birth _____

hereby authorize: _____

address: _____

_____

to release information contained in my (or my dependent's) records to the following individual(s) and/or organization(s), and only under the conditions listed below:

1) Name of person(s), organization(s), address to whom disclosure is to be made:

_____

_____

_____

2) The purpose and/or need for such disclosure:

_____ Provision of Mental Health Services _____Billing Purposes _____Discharge Planning
_____ Continuity of Treatment _____ Family Involvement _____Other: _____

3) Specific Information to be disclosed:

_____Diagnosis _____Drug/Alcohol Hx _____Tx Summary _____Attendance
_____Progress Notes _____Physical Exam _____ Prognosis _____Discharge
_____Entire Record _____Psychological Test Results _____Other: _____

4) This authorization is valid only for the information, agencies, and persons cited above and for no longer than 180 days after the client's (or client guardian's) signature/date on this form. Grace Counseling Center is not responsible for the forwarding and/or copying of information once it is sent to agencies/persons cited above. If the client discontinues treatment prior to the allowed time period, this authorization will be considered void as of the date of the client's termination of treatment.

5) You have the right to revoke this authorization, in writing, at any time by sending such written request to the Grace Counseling Center. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization prior to your receipt of your revocation. Your revocation will also not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____
(Client or guardian) (Date)

_____ _____
(Witness) (Date)