2013

Teaching-Family Homes of Upper Michigan
Release of Information Consent Form

I, _____, authorize Teaching Family Homes of Upper Michigan to release _____ and/or request _____ information from the record of _____ DOB
(Name of Client)
to the following agency or person:

_____
Name Address City State Zip Code

( ) Academic Testing Results ( ) Psychological Testing Results ( ) Intelligence Testing Results
( ) Behavior Programs ( ) Service Plans ( ) Vocational Testing Results
( ) Case Notes ( ) Summary Reports ( ) Medical Reports
( ) Personality Profiles ( ) Progress Reports ( ) Psychological Reports
( ) Entire Record ( ) Unrestricted two-way communication ( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program ( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program ( ) Case Review
( ) Updating Files ( ) Other (specify) _____
_____

I understand that my treatment is not conditioned on my providing authorization for this request. I understand that I can examine or copy the information being released. If the information being released with result directly or indirectly in remuneration (payment) form a third party, I must receive a statement in writing.

I understand that this consent automatically expires one year from date of signature, or at the time the client completes treatment. I understand that I may refuse to sign the authorization. I understand that I may revoke this consent at any time by providing written notice.

I have been informed what information will be given, its purpose, and who will receive the information. *I understand that clinical records containing information about substance abuse and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) require authorizing initials. _____ (Recipients initials).

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness (if client is unable to sign)_____ Date_____

Signature of Person Informing Client of Rights _____ Date_____

* Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.