Robin Kahler, L.M.S.W., A.C.S.W.

1817 W. Stadium, Suite I, Ann Arbor, MI 48103 (734) 645-0580

**Authorization for Release/Request of Client Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(client/parent) whose date of birth is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize

Robin Kahler LMSW, ACSW, 1817 W. Stadium, Suite I, Ann Arbor, MI 48103 to obtain client records from or disclose to

**(\*\*\*please put your initials in only ONE area)**

\_\_\_ Psychiatrist Communication to coordinate treatment

\_\_\_ Probation Officer Communication to coordinate services

\_\_\_ Family Involvement

 \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

whose name is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and complete address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, authorize the following information to be released: assessment, intake paperwork, demographic information, diagnosis, psychosocial evaluation, psychological evaluation, treatment plan and updates, medication, participation in treatment, medical information, educational information, discharge summary, continuing care planning, progress in treatment, progress notes.

For the purpose of coordination of care.

I further understand that Robin Kahler, LMSW will not condition my treatment on whether I give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is more strict than HIPAA and provides additional privacy protections.

This consent automatically ends when its purpose has been achieved, or 60 days after the date below, whichever is later.

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Client Signature (or Parent’s) Date

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Child’s Name if client Date

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Therapist Signature/Witness Date

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**(\*\*\*DO NOT SIGN HERE UNLESS YOU ARE REVOKING THE RELEASE)**

I understand that I can revoke this release at anytime. By signing here, I am canceling this release. Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dated \_\_\_\_\_\_\_\_\_\_\_\_\_ updated release 3/2017