Heather N. Lettow MA., LPC., LMFT
Release of Information

Recipient Name Case Number Date of Birth

I hereby authorize Heather N. Lettow, MA., LPC., LMFT., to [ ]Send [ ] Receive [ ] Exchange the specified information [ ] to [ ]from [ ] between Heather N. Lettow, MA., LPC., LMFT., and the person/organization named herein:

The confidential information may be released in the following forms: [ ] written [ ] verbal [ ] electronic

The authorization is valid between __/__/__ and __/__/__ for documents created between __/__/__ and __/__/__. This authorization, except for action already taken, can be revoked at any time by verbal or written notice, or upon discharge from services notice.

Document Contents

[] Mental Health [] Substance Abuse [] HIV/AIDS [] Medical

Document/Information For Exchange (check all that apply)	
[] Demographics	**Other**
[] Contact Information	[] Court Services
[] Insurance	[] Legal information
Mental Health/Service History	[] School records
[] Intake	[] Department of Human Services
[] Progress Notes	[] Notice of start of service
[] Billing information	[] Notice of end of service
Medical	[] Representative payee
[] Physicians notes	[] Other
[] Diagnosis	
[] Medication	

Purpose of Release (check all that apply)

Healthcare Integration	Emergency Contact	Communicate w/ Primary Care
Coordination of Care	Evaluation/Assessment	Court Proceedings/Records
Billing Information	Status Reports	Other:

Statement of Understanding

- I understand that authorizing the request/disclosure of information in my records is voluntary, and is not a condition for the treatment, payment, or eligibility for benefits of service.
- My signature means that I have read this form and/or have had it read to me and explained in language I can understand
- I understand that as the recipient/parent/guardian who signed this form can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, HIIPA, and any other applicable laws, rules and regulations.
- I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by the Federal Confidentiality Laws.
- I may withdraw my authorization at any time. I understand also that such withdrawal of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.
- Information related to my HIV states may be disclosed under the provision of law MCL333.5131.

_____ _____ _____ _____

Recipient Signature Date Parent/Guardian/Representative Signature Date

_____ _____

Witness Signature Date