***McCaskill Family Services, PLLC***
*409 Plymouth Road, Suite 250, Plymouth, MI 48170*
*2040 Grand River Annex, Suite 300, Brighton, MI 48114*
*734-416-9098, Ext. 1 • www.mccaskillfamilyservices.com •office@mccaskillfamilyservices.com*

# AUTHORIZATION FOR RELEASE OF INFORMATION

**CLIENT NAME: _____ BIRTHDATE:_____**

**Authorization is hereby voluntarily granted to the administrative staff, clinicians, and independent contractors at McCaskill Family Services.**

❑ **This authorizes McCaskill Family Services, PLLC to request information from: (and/or)**

❑ **This authorizes McCaskill Family Services, PLLC to release records to:**

Name/Organization: _____

Address: _____

Fax: _____ Phone: _____

**INFORMATION TYPE (Please check all that apply):**

❑ Psychological testing/assessment records (including comprehensive evaluation reports with specific subtest standard/scaled scores, diagnostic conclusions, etc.)
❑ Medical/Psychological treatment summaries/service plans
❑ Academic records (including any/all report cards, evaluation reports, formal/informal accommodation plans, standardized testing scores)
❑ Medical records (e.g., treatment notes, medication history, diagnostic information)
❑ Session attendance
❑ Diagnostic information
❑ Billing/payment information
❑ All of the information listed above

**PURPOSE OF RELEASE:**

❑ Treatment/Service Coordination ❑ Assisting with Evaluation ❑ Treatment/Service Planning
❑ Continuity of Care ❑ All of the above purposes
❑ Other (Please Specify): _____

**This authorization shall remain in effect until:** _____or until_____.
(Desired expiration date) (Event)

- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to McCaskill Family Service's office address. However, the revocation will not be effective to the extent that any authorized clinician(s) has taken action in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian (if needed) Date

*(If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.)*