Mind & Spirit Counseling, LLC

44444 Mound Road, Suite 620, Sterling Heights, MI 48314
Phone #: 586.859.0030

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

<table>
<tr><td colspan="3">Name</td><td colspan="3">Date of Birth</td></tr>
<tr><td colspan="3">Address (number and street)</td><td colspan="3">Phone Number</td></tr>
<tr><td>City</td><td>State</td><td>ZIP Code</td><td colspan="3">County</td></tr>
<tr><td colspan="3">Parent/ Guardian Name</td><td colspan="3">Parent/ Guardian Phone Number</td></tr>
<tr><td colspan="3">Parent/ Guardian Address (if different than client)</td><td>City</td><td>State</td><td>ZIP Code</td></tr>
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I ____ authorize Mind & Spirit counseling, LLC
print full name

to release the most current medical information (from the past 12 months), which may include reports, letters from specialists, office or hospital inpatient or outpatient summaries that review status of medical problems and ongoing treatment plans, to a person or organization as identified below:

Please initial to verify permissions granted

_______ Send information

_______ Receive information

Person or organization Authorized to send/receive information:
Name: ____
Street Address: ______________________________________
City: _____________________State: _______ Zip code: ___________
Phone number: ___________________________________

- I understand that any protected health information disclosed using this Authorization may potentially be re-disclosed by the individual or organization named above and its privacy will no longer be protected by the federal privacy law.
- I understand that I can revoke this authorization at any time if I change my mind for any reason. An authorization revocation can be done in writing. Any information already released or disclosed with my permission before authorization is revoked cannot be undone.
- I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility unless the information is necessary to demonstrate that I meet the criteria required to establish eligibility.
- I understand, I may request a copy of this signed authorization.

Unless revoked, this authorization expires 12 months from the date signed.

Signature of Client: ____ Date signed: ______________________
(Parent or Legal Guardian if client is a minor)

Signature of Witness: _______________________________________ Date signed: _______________________
(any adult over the age of 18)

Mind & Spirit Counseling does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: Public Act 368, P.A. of 1978