Healing Perspectives: Time Well Spent, Counseling and Resource Center, LLC
5600 West Maple Rd. Suite B-212 West Bloomfield, MI 48322
Phone: 248-605-5049 Fax: 844-371-7126

Authorization to Disclose Protected Health Information

I, _____(client/guardian),
hereby authorize **Laurel Jean Rebenstock, LMSW, CAADC** of **Healing Perspectives: Time Well Spent, Counseling and Resource Center, LLC (Provider)** to disclose to and/or receive information from:

Name _____

Address _____

_____

_____

Phone _____ Fax _____

To include the following protected health information:

____ Entire File ____ Psychotherapy Notes ____ Session Start/Stop Times
____ Diagnosis ____ Treatment Plan ____ Recommendations
____ Progress to Date ____ Dates of Treatment
____ Other _____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. I authorize the disclosure of the health information described above for the following purpose:

_____
_____

The specific uses and limitations on the uses of my health information by Recipient are as follows:

_____
_____

I understand that Provider cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Michigan law.

Provider is authorized to disclose the protected health information specifically listed above until:
_____(authorization expiration date or case closure).

By: _____/_____ Date: _____
(Signature of Patient or Patient's Representative)/Printed Name
*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:
_____