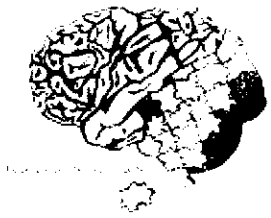

NORTHERN
MICHIGAN PSYCHIATRIC SERVICES, P.C.

3287-A Racquet Club Drive
Traverse City, MI 49684

Telephone: (231) 935-0355
Fax: (231) 935-0360

Sander Weckstein, M.D.
Ethan Weckstein, D.O.
Sarah Chichester, P.H.M.N.P.-B.C.
Wendy Weckstein, P.T., M.Ed., C.B.I.S.

Kathleen Blazejewski, L.M.S.W.
Lynda Key, L.M.S.W.
Sarah Rademacher, L.M.S.W.

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I, the undersigned patient/parent/legal guardian, hereby authorize Northern Michigan Psychiatric Services, P.C. and any of its agents to obtain and release medical record information concerning the treatment of the above named patient.

Name of Organization: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

SPECIFIC MEDICAL RECORD INFORMATION TO BE RELEASED

Release dates: From _____ To _____ ☒ Any and all Dates

- ☒ Entire medical/mental health record
- ☒ Verbal exchange
- ☒ Treatment records
- ☒ Psychiatric evaluations
- ☒ Psychological testing records
- ☒ Substance abuse treatment records
- ☒ Laboratory studies/x-rays
- ☒ Billing and insurance records

I understand that such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand information to be disclosed may include treatment of psychiatric, substance abuse, and HIV/AIDS related illnesses. I agree the information may be faxed for expediency. I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above address. I understand that a revocation is not effective to the extent this office has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to inspect or obtain a copy of the health information, and may refuse to sign this authorization. If not specifically revoked in writing, this consent remains in effect for 10 years. I understand and consent for the medical record of the patient listed above to be copied and sent to and received from the organizations as indicated above.

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258of 1974 as amended, Section 758.759.750). The released information may not be copied, shared, or re-released, except as consistent with the authorized purpose stated above. This authorization is in compliance with Title 42 of the Code of Federal Regulations Part II which also prohibits disclosure.

I have also had to the opportunity to have this form explained to me and have my questions answered.

_____

Patient Signature Date

_____

Legal Guardian Signature Date
(If appropriate)

Confidential information: any further release of this document without additional authorization by the patient will be a breach of confidentiality. Federal Regulation (2 CFP, Part 2) and State Laws (P.A. 258. Chapter 7. Section 748 in Parentheses) DDK 10/02.1/03.5/03.