BALANCED LIFE COUNSELING LLC
RELEASE OF CONFIDENTIAL INFORMATION

Name: _____ **Date:** _____

Address: _____ **D.O.B.:** _____

_____

Social Security #: **(last 4 digits)** _____

I hereby authorize **BALANCED LIFE COUNSELING LLC**

950 West Monroe St., SUITE G100 /JACKSON MI 49202

(517)962-5022 **FAX: (517)962-5195**

to release, request/receive the information from agency named below:

Name: _____

Address: _____

Phone #: _____

Check box:

[ ] ___ Diagnosis	[ ] ___ Psychiatric Evaluation	[ ] ___ Schools/Records/Behaviors
[ ] ___ Psychological Test	[ ] ___ Psychosocial History	[ ] ___ Insurance Information
[ ] ___ Treatment Plan	[ ] ___ Treatment Progress Notes	[ ] ___ Sub Abuse HX
[ ] ___ History/Physical	[ ] ___ Lab/Drug Screens	[ ] ___ Medical Information
[ ] ___ DHS/Social Security		[ ] ___ Other

Reason for disclosure:

[ ] Determine need & type of treatment [ ] Coordination of services [ ] Other _____

If revoked please describe circumstances: _____

_____

_____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that an action may have already been taken. In any event, this consent expires one year from the date of signature or 60 days after the date of my discharge from BLC's services unless otherwise specified below.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information Is NOT sufficient for this purpose. The above is FOR PATIENT'S RECORDS APPLICABLE UNDER FEDERAL LAW 42CFR PART 2.

_____ Consumer [ ] Guardian [ ] _____

Consumer/Guardian Signature Date

_____ _____

Witness Signature Date

Revised 10/17/18File location: Desktop BLC; Filename: Release of Conf Info