**** Administrative Office

Integrative Counseling and Psychological Services 1777 Axtell Dr., Suite 100, Troy, MI 48084

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| **Release of Information / Two-Way Authorization Form**   |  | | --- | | I,  **(CLIENT PRINTED NAME)** |   hereby authorize Sollars & Associates its director or agents, to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization. However, such communication may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.    \*Not for use for disclosure of psychotherapy notes.   |  |  | | --- | --- | | Primary Care Physician/  Person/Agency/Facility |  | | Address |  | | Phone |  | | Fax |  | | TODAY’S DATE |  |  |  |  | | --- | --- | |  | The purpose or need for such disclosure (check appropriate box on the left) | |  | At the request of the patient | |  | School | |  | Continuation of Care | |  | Attorney | |  | Insurance | |  | Coordination of Care | |  | Disability | |  | Other |      |  |  | | --- | --- | |  | Specific information to be disclosed/obtained as related to above (check appropriate box on the left) | |  | Record of Visits | |  | Treatment Plan | |  | **Diagnosis**   |  | | --- | |  | | |  | **Frequency of Visits**   |  | | --- | |  | | |  | Termination Summary | |  | Treatment Summary | |  | Other |  * This authorization is valid only if received by Sollars & Associates within 60 days of the date signed. * Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on date listed in the box below. The date cannot exceed one year from the date of signature below.  |  | | --- | |  |  * I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization. Contact Sollars & Associates at 1777 Axtell St., Suite 101, Troy, MI 48048 * 7. My care or treatment will not be conditioned on signing this authorization. * 8. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient’s knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law. * 9. Sollars & Associates reserves the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or healthcare facility.   **Check here**   |  | | --- | |  |   **and sign this form if you do *not* wish to coordinate care with your Primary Care Physician at this time.**   |  |  | | --- | --- | | Client Printed Name |  | | Client Signature and Date |  | | Relationship (if other than client) |  | | Therapist Printed Name |  | | Today’s Date |  |   Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA\*  \* If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release. |