Melissa R. Tower
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AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE RECORD OF:

NAME: _____ DATE OF BIRTH: _____

I hereby authorize: Melissa R. Tower, MA, LLP, CPC 4829 East Beltline NE to release specific information from my record to / and receive referral information from: (Name, position, address)

_____

I understand that my continued or future treatment by or payment to Melissa R. Tower MA, LLP, CPC is not conditioned upon my providing or signing this authorization. The information to be released is limited to the following records specified by description and date, and may include information about drug/alcohol usage, if applicable:

_____
_____

The information to be released is to be used ONLY for the following authorized purpose:

_____
_____

The authorization is effective for the following period of time (12 months or less):
From _____ To _____

My authorization is withdrawn if any of the following occur:

EVENT: _____

CONDITION: _____

I understand that I may withdraw with release at any time by notifying the agency holding my records.

Signature: _____ Date: _____
Client or Legal Guardian / Parent of Minor

Release Obtained by: _____ Date: _____

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258 of 1974 as amended section 748 (3). This means that the released information may not be copied, shared, or released except as consistent with the authorization purposed stated above. This release is in compliance with Title 42 of the Code of Federal Regulations, Part II, which also prohibits re-disclosure. Information concerning HIV status must be specifically requested.