SECOND CHANCE
COUNSELING CENTER LLC

Release of Information

Client Name:
Birth Date:
☐ Release Information To
☐ Request Information From
The Individual/Organization listed below and only under the conditions listed below:

Name and Address of Person or Organization:

Send to: Second Chance Counseling Center
3890 Charlevoix Ave Suite 306
Petoskey, MI 49770
Fax: 231-881-9132

Specific Information to be disclosed:

☐ Attendance
☐ Psychological
☐ Medical Records
☐ Assessment
☐ Psychological History
☐ Progress Report
☐ Aftercare Plan
☐ Treatment Plan
☐ Discharge Summary
☐ Appointments & Cancellations
☐ Substance Use Assessment
☐ Recommendations

Purpose and Need for Disclosure of Information:

☐ Continuation of Care
☐ Disability Determination
☐ Vocational Rehabilitation
☐ Social Service Referral
☐ Driver License Appeal Hearing
☐ Legal Follow Up
☐ Family Participation
☐ School
☐ Other: MDHHS

I understand my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Without expressed revocation, this consent expires for the specified reasons:

A. Date: One Year to Date
B. Event: 90 Days from Date of Discharge
C. Condition: Whichever Comes First

Client Signature ____________________________ **Date** ________________

Witness Signature:
Date:

Phone: (231) 881-9125 ● Fax: (231) 881-9132 ●
3890 Charlevoix Ave Suite 306 ● Petoskey, MI 49770