Recco S. Richardson Consulting, Inc.
3456 Pierson Pl., Suite C
Flushing, MI 48433
(810-394-7815)

AUTHORIZATION FOR RELEASE OF INFORMATION

I_____(client name), hereby authorize Recco S. Richardson Consulting, Inc and its director or designee,_____(therapist name) , to release information contained in my client records to the individual or organization under the conditions listed below:

1. ☐Request of Records from
   or
   ☐ Name of person or organization to which disclosure is to be made:

   Name:_____
   Address: _____
   Telephone Number: _____
   Fax: _____

2. Specific type of information to be disclosed:
   ☐ Client Records
   Other:_____

3. The purpose and need for such disclosure:
   ☐Collaborative Care
   Other:_____

4. This consent is subject to being revoked at any time. However, any consent given under subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration of no longer than that reasonably necessary to effect the purpose for which it is given, which is 6 months. If longer than 6 months, the established time frame is : _____

5. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer.

_____ X_____
Witnessed by Client's Signature

_____ X_____
Date Witnessed Date Signed

This form is in accordance with the authority specified in Public Act 56 of 1973, and is in compliance with Title 42 of Code of Federal Regulations Part II.