WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Notification & Coordination with Education Professionals

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information	
Client Name:	**Client DOB:**
Parent/Guardian:	
School Name: _____	
Address: _____	
Phone #: _____	**Fax #:** _____
School Representative(s): _____	

It is helpful for your therapist to coordinate with your school. Please indicate below whether you chose to give consent for the release of any or all information in this coordination with your school system.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed.
If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the school representative(s) identified above. I hereby authorize, Hoxworth Counseling Services its director or designee, to release and/or exchange protected health information to the individual(s) or organization listed above.
Extent of information to be disclosed: ☐ **Verbal Exchange or Written Summary or** ☐ **Other:** _____

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

----------OR----------

☐ My therapist has explained to me the importance of coordinating educational and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with the school representative(s).

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

For Office Use Only:

Therapist Name: _____
Current Diagnosis: _____
_____
Other Clinical Information: _____
_____
Hoxworth Counseling Services Staff – Faxed by: _____ *Date:* _____