ASSURANCE COUNSELING, LLC

LATRESA L. WILLIAMS, BSW, ACSW, LMSW
Licensed Clinical Therapist
31584 Schoolcraft Road
Livonia, Michigan 48150
Phone: 248.491.8417 Fax: 313.278.3690

CLIENT NAME: _____ Date of Birth: _____

ADDRESS: _____ Social Security # _____

CITY: _____ STATE: MICHIGAN ZIP CODE: _____

I _____, authorize Assurance Counseling, LLC to disclose or request **(circle one)** information in my record to from:

_____
Name of Individual and/or Facility

_____
Address

Specific Information to be released/requested:

- □ Assessment
- □ Progress Notes
- □ Treatment Planning and Review
- □ Verification of treatment

Purpose or need for disclosure or request **(circle one)**: **Confirmation of attendance**

This consent authorizes the release of protected health information contained in my records, including alcohol and substance abuse records, protected under the Regulations in 42 CFR, Part 2, and Regulations in 45 CFR (HIPAA) if any; psychological services records, if any; social services records, if any; HIV, ARC, AIDS records, if any.

This consent is subject to revocation at any time except in those circumstances in which Assurance Counseling, LLC has acted upon the signed authorization. This consent will continue if un-revoked until the purpose for which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 52-Number 110, July 9, 1987, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it was given.

Without expressed revocation, this consent expires within (90) days or upon completion of this request or release (circle one) or for the following specified reason:

Condition: _____ Date: _____ Event: _____

_____ _____
Client/Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date