Center for Integrative Psychology

Barry Jay, Ph.D.

Authorization to Release Information

RE: _____ ***DOB:*** _____

I hereby authorize the release and exchange of information contained in the records of the above named person between the following parties:

Center for Integrative Psychology
7001 Orchard Lake Rd., Ste. 124
West Bloomfield, MI 48322

and _____
_____
_____
_____

The specific information to be disclosed is: _____

_____

The purpose and need for this disclosure is: _____

_____

This authorization is valid only for the information, agencies and persons cited above, and **FOR NO LONGER THAN TWELVE MONTHS** after the date of this form. I understand I may revoke this authorization in writing at any time prior to the expiration. Any redisclosure of this information is not permitted without my specific authorization to do so.

_____ _____
Signature of Parent, Guardian or Recipient Witnessed by

_____ _____
Relationship to Recipient Date

This information release authorization form has been prepared in order to be in compliance with Title 42 of the Code of Federal Regulations, Part II, in accordance with the authority specified in Public Act 56 of 1973; and in compliance with Section 748, Act 258, "Mental Health Code."