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## AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

I/we \_\_\_\_\_ authorize \_\_\_\_\_  
(parent or legal guardian or client) (program, school, clinical personnel)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to release information from the record of \_\_\_\_\_, d.o.b. \_\_\_\_\_  
(student)

to **E. Gordon Associates, Inc.** The purpose for disclosure is to provide continuance of care and consulting services. Items requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature means that I have read this form or have had it read to me and explained in language I can understand. The receiver of this information is required by Michigan Department of Mental Health Code (SECS. 748 and 750) to ensure and protect the confidentiality of all information released to the receiver. Any information contained in record(s) of the above-named individual, including alcohol and drug abuse records, are protected under the regulations in Code 42 of Federal Regulations, Part 2. Any redisclosure of information must be in accordance with the Mental Health Code and with the statutes of the State of Michigan.

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Client if over age 18 \_\_\_\_\_

A copy of this authorization may be the equivalent of the original.