Ascension Michigan
Behavioral Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, *(Patient Name)*_____

hereby authorize _____its Director or Designee, or Medical Records Department, to release information contained in my client records, including alcohol and drug abuse records protected under 42 Code of Federal Regulations, Part 2, if any; psychological services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

1. Name or person or organization, to whom disclosure is to be made:

   Name: _____

   Street Address: _____

   City: _____ State:_____ Zip Code: _____

   Phone: _____

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

2. Specific type of information to be disclosed:

   The authorizing person must place their initials next to the type of information to be disclosed:

_____ Diagnosis	_____ Drug/Alcohol History***	_____ Treatment Summary
_____ Attendance	_____ Mental Status Exam	_____ Treatment Progress
_____ Prognosis	_____ Physical Examination	_____ Discharge Summary
_____ Medication Review	_____ Intake/Assessment	_____ Psychiatric Evaluation
_____ Emergency Only	_____ School Records – Specify:_____	
_____ Other – Specify: _____		

*** This information has been disclosed to you from records protected by Federal Confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

3. The purpose and need for such disclosure:

   The authorizing person must place their initials next to the purpose/need for such disclosure:

_____ Provision of Behavioral Health Services	_____ Billing Purposes	_____ Continuity of Care
_____ Emergency Contact	_____ Family Involvement	_____ Aftercare Planning
_____ Employer Request	_____ Worker's Compensation	_____ Attorney Inquiry
_____ Disability Certification	_____ Social Security	_____ School Coordination
_____ Other – Specify: _____		

4. This consent can be revoked, in writing, at anytime except to the extent that information has already been released by the Hospital/Facility. Any consent for the release of drug and alcohol abuse records shall end when the purpose for the release has been achieved. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.

5. This consent will expire automatically when the purpose for the release has been achieved or upon 90 days after the date below, whichever is later.

   Signature of Client:_____Date / Time:_____

   Birthdate of Client:_____Social Security Number of Client:_____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Client is Unable to Sign or is a Minor

(1)
Signature of Guardian, Pt. Advocate
of Personal Representative: _____

Date/Time:_____Relationship: _____

Address:_____Phone #: _____

(2)
Signature of Guardian: _____

Date/Time:_____Relationship: _____

Address:_____Phone #: _____

Signature of Witness: _____ Date / Time:_____