Isabella Citizens for Health

2790 Health Pkwy
Mt. Pleasant, Michigan 48858

Authorization for Release or Disclosure of Health Information (Behavioral Health)

______________________________ ________________ ________________
Patient Name Birthdate Social Security Number

I, __________________ (Patient/Legal Representative), authorize Isabella Citizens for Health and the individuals or organizations listed to:

(Initials Required)

RELEASE information to _______ **OBTAIN** information from _______ **EXCHANGE** information with ___X____

Name, title, and address/contact of Clinic/Doctor/Organization/Individual to whom disclosure is made:

____
Name & Title

____
Address City/State/Zip

____
Phone/Fax (If available)

The purpose and need for disclosure:

☐ Individual Access Request	☐ Continuation of Care	☐ Transfer of Care
☐ Emergency Contact	☐ Payment of Bill	☐ Legal Follow-Up (i.e., Attorney, Court, Probation)
☐ Social Service Referral	☐ Disability Determination	☐ Vocational Rehabilitation
☐ School	☐ Medical	☐ Other______________________

Specific type of information to be disclosed : The information indicated below may be disclosed from my treatment records, covering the dates from ______________ to **end of current treatment episode.**

Please initial below

***☐ Diagnosis, placement and treatment recommendations (including integrated summary)

***☐ Monthly progress report (including attendance) ***☐ Drug Screen Results

***☐ Continuing Care Plan/Discharge Summary ***☐ Treatment summary

***☐ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

☐ Other ____

☐ Excluding the following information ______________________________________

- Mode of communication includes fax, mail, phone, and in person.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. This consent expires automatically as follows:

***☐ Event: 6 months following termination of services (maximum of one year from date of signature)

I understand that generally Isabella Citizens for Health may not condition my services on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

By signing below, I authorize the disclosure of the above named individual’s health information as described above.

______________________________________ ________________
Signature of Patient or Legal Representative Date

____
If Signed by Legal Representative, State Relationship to Patient

______________________________________ ________________
Signature of Witness Date

This information has been disclosed to you from records protected by federal confidentiality rules (CFR 42, Part 2).
The federal rules prohibit any further disclosures 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 CFR42, Part 2. A general authorization for the information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.