Macomb County Community Mental Health

Client Release of Information

INDENTIFYING INFORMATION			
SERVICE/ DOCUMENT DATE	CONSUMER NAME	CONSUMER CASE #	CONSUMER DATE OF BIRTH

I hereby authorize Macomb County Community Mental Health to release information from my clinical record to:

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

SPECIFIC INFORMATION TO BE REQUESTED/DISCLOSED

☐ Notice of start/receipt of services	☐ Initial Assessment	☐ Psychiatric evaluation
☐ Personal identifying information	☐ Diagnosis	☐ Psychiatric notes
☐Name ☐ Age ☐ SSN	☐ Substance abuse	☐ Annual assessment
☐ Notice of end of services	☐ Dietary assessment	☐ Psychological testing
☐ Physical therapy assessment	☐ Psychological assessment	☐ Psychotherapy notes
☐ Occupational therapy assessment	☐ Progress notes	☐ Medications
☐ Individual plan of service/treatment plan	☐ HIV/AIDS/ARC related	☐ Financial information
☐ Alchohol/substance abuse	☐ Physical exam	
☐ Educational ☐Legal		

LAB REPORTS TYPE	MEDICAL INFORMATION	OTHER

NOTES

PURPOSE OR NEED FOR REQUEST/DISCLOSURE

☐ Communication with primary care physician	☐ Billing/Payment
☐ Provision/Continuation of services	☐ Eligibility determination
☐ MI statewide homeless management information system	☐ Evaluation/Assessment
☐ Coordination of care	☐ Emergency contact
☐ Medication review	☐ Aftercare planning

OTHER

● I understand that authorizing the request/disclosure of information in my records is voluntary, and that my services will not be affected if I choose not to sign this form.

● I understand that I as the client/parent/guardian who signed this form can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, and any other applicable laws, rules and regulations.

● I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized redisclosure and the informaton may not be protected by Federal Confidentiality Laws (P.L. 104-191 (HIPAA), 45 CFR Parts 160 and 164).

This authorization, except for action already taken, can be revoked at any time by verbal or written notice.
Without expressed revocation this authorization expires after one year, or sooner for any one or more of the following reasons:

A. Date:
B. Event:
C. Condition:

Client Signature	Date	Parent/Guardian/Representative Signature	Date
Witness Signature	Date	Second Witness Signature (if telephone request)	Date

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IF ALCOHOL OR DRUG ABUSE TREATMENT INFORMATION IS RELEASED: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other 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.

FOR ANY RELEASED CONFIDENTIAL INFORMATION: Pursuant to MCL 330.748(3); MSA 14.800(748)(3), the individual or organization in receipt of this confidential information shall redisclose this information to others only to the extent consistent with the authorized purpose for which the information was obtained.