



Client Release of Information

IDENTIFYING INFORMATION

Table with 4 columns: SERVICE/ DOCUMENT DATE, CONSUMER NAME, CONSUMER CASE #, CONSUMER DATE OF BIRTH

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

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.

SPECIFIC INFORMATION TO BE REQUESTED/DISCLOSED

Grid of checkboxes for various information types: Notice of start/receipt of services, Personal identifying information, Initial Assessment, etc.

LAB REPORTS TYPE, MEDICAL INFORMATION, OTHER

NOTES

PURPOSE OR NEED FOR REQUEST/DISCLOSURE

Grid of checkboxes for purposes: Communication with primary care physician, Billing/Payment, etc.

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 information 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:

Signature lines for Client, Parent/Guardian/Representative, Witness, and Second Witness.

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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.