

The Center for Counseling

Your Life Is Precious.™

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New Baltimore, MI 48047
Phone 586.273.7095, Fax 586.273.7196

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client/Guardian

Date of birth

I hereby freely and voluntarily authorized The Center for Counseling to.....

_____ Release/disclose my protected health information to:

_____ Obtain my protected health information from:

(Individual, Facility, or Organization)

(Phone Number)

(Address)

(Fax Number)

(City, State, Zip Code)

The purpose of this disclosure is for:

_____ educational placement

_____ legal reasons

_____ Insurance/billing

_____ medical treatment

_____ discharge planning

_____ continued treatment

_____ The client

_____ progress update

_____ other _____

Information to be used or disclosed:

_____ Discharge summary

_____ psychiatric eval

_____ mental status

_____ History

_____ testing

_____ treatment plans

_____ Progress

_____ attendance

_____ prognosis

_____ Drug/alcohol history

_____ entire record

_____ other _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to The Center for Counseling, except to the extent that action has already been taken in reliance on it. This authorization will expire 90 days () following discharge, or () following signature unless another date or condition is specified. Other date or condition specified: _____

Client/Guardian

Date

Witness

Date

*Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.