MBC

MICHIGAN BEHAVIORAL CONSULTANTS

Authorization For Use Or Disclosure Of Protected Health Information

Patient Name:			Date of Birth:
Address			
City	State	Zip	Telephone

The following individual or organization is authorized to make the disclosure:

☐ Michigan Behavioral Consultants 61 Commerce Ave SW, Grand Rapids, MI 49503 FAX 616.242.2517

☐ Other (please specify)_____

This information may be disclosed to and used by the following individual or organization:

☐ Michigan Behavioral Consultants, 61 Commerce Ave SW, Grand Rapids, MI 49503 FAX 616.242.2517

☐ Other (please specify)_____

Address: _____

City State Zip Phone Fax

Treatment Dates	Purpose of Request

The following information is to be disclosed (at least one must be checked):

Yes	No		Yes	No	
☐	☐	Discharge Summary	☐	☐	Dictation
☐	☐	Consultations (including psychiatric evaluations)	☐	☐	Cardiac studies
☐	☐	Operative report or procedure reports	☐	☐	Nursing notes
☐	☐	Emergency Department record	☐	☐	Physician orders
☐	☐	Laboratory reports (including drug screens)			
☐	☐	Radiology or imaging reports			
☐	☐	interdisciplinary records (progress notes)			
☐	☐	Medication records			
☐	☐	Complete record			
☐	☐	Other, _____			

I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Unless otherwise revoked, this authorization will expire on the following date or when the following event or condition occurs.

_____

If I do not specify an expiration date, event or condition, this authorization will expire in 12 (twelve) months.

I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.

Signature of Patient or Legal Representative *Date*

Relationship to Patient *Witness (second witness if signed with an "x")* *Date*

Fee Letter Sent

☐ Yes ☐ No

Copies are to be

☐ Mailed ☐ Picked Up ☐ Faxed (#)