AUTHORIZATION FOR RELEASE & DISCLOSURE, AND/OR REQUEST FOR MEDICAL INFORMATION & RECORDS

CONFIDENTIAL

I (Patient): _____, (Date of Birth): _____
authorize Cheryl Cooper to: (select one or both or this form is invalid)

- ☐ Release information from my medical records to the individual/organization listed below
- ☐ Request information from the individual/organization listed below

Name: _____
Address: _____
For the following purpose, use, or need: _____
_____
The following information from my psychiatric/medical records may be disclosed, covering the dates from: _____ to: _____:

- ☐ Treatment Summary ☐ Psychiatric Evaluation ☐ Psychological Testing
- ☐ Physical Exam ☐ Laboratory Studies ☐ Initial Assessment
- ☐ Exchange of all written material and verbal health information pertinent to the coordination of my care and treatment
- ☐ Other: _____
- ☐ Exclude the following information: _____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual/organization listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748 749 and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations, Part II, with which this authorization complies. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Cheryl Cooper will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition: _____
_____
I have also had the opportunity to have this form explained to me and have my questions answered.

Patient/Parent/Guardian/Personal Representative:

_____ _____
SIGNATURE DATE

Witness:

_____ _____
SIGNATURE DATE

Copy of this authorization provided: ☐ Yes ☐ Declined

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