COMMUNITY MENTAL HEALTH
OF CLINTON-EATON-INGHAM COUNTIES
AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME _____ DOB _____ CLIENT # _____

I give permission to release information pertaining to *My / My Child's / My Ward's care*:

FROM: COMMUNITY MENTAL HEALTH - CEI
(Organization / Person)
812 E. JOLLY ROAD, SUITE G-9
(Address)
LANSING, MI 48910

Phone: P: 517-346-8264 F: 517-346-8319

TO: RECORDS DEPOSITION SERVICE, INC.
(Organization / Person)
P.O. BOX 5054
(Address)
SOUTHFIELD, MI 48086-5054

Phone: P: 248-357-3330 F: 248-357-3337

*I UNDERSTAND THAT APPROPRIATE INFORMATION FROM MY CLINICAL RECORD MAY BE RELEASED VIA **FACSIMILE** WHEN NEEDED FOR IMMEDIATE CLIENT CARE (AS DEFINED IN CLINICAL POLICIES 3.3.10 AND 3.2.14).*

*I UNDERSTAND THIS RECORD MAY CONTAIN MENTAL HEALTH, DRUG AND/OR ALCOHOL USE/ABUSE HISTORY, HIV, AIDS OR ARC INFORMATION, AS APPLICABLE TO **MY / MY CHILD'S / MY WARD'S** CASE.*

The *PURPOSE* for the release of this information is: ☐ Continuity of Care ☑ an attorney/court request

Other (specify): _____

SPECIFIC RECORDS / INFORMATION TO BE RELEASED *FOR THE TIME PERIOD: FROM* _____ *TO* _____

☐ Assessments ☐ Psychiatric / Psychological Evaluations / Testing ☐ Physician's History and Physical
☐ Discharge Summaries

Other (specify): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

This authorization will expire on the following date_____, or on the following event/condition _____.
This authorization will last no longer than reasonably necessary to serve the purpose for which it is given. I understand that I may withdraw this authorization at any time, unless action has already been taken based on this authorization. CEI-CMH will not condition treatment, payment, or program eligibility on the signing of this authorization but I understand that in certain limited circumstances I may be denied treatment if I do not sign this form.

I have read, or have had read to me, this authorization form and understand what it means.

_____
Client / Parent / Guardian Signature or Person Authorized to Sign in Lieu of Client — Relationship — Date

_____
Witness to the Above Signature

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FURTHER DISCLOSURE OF THIS INFORMATION IS PROHIBITED UNLESS OTHERWISE PERMITTED BY FEDERAL AND STATE LAWS. **(P.A. 258 of 1974, Section 748(3); P.A. 368 of 1978; 42 CFR Part 2; 45 CFR Parts 160 and 164 (HIPAA); P.A. Act 488 of 1989)**

CMH 2921012 Rev9/06

Distribution: **Original to Person Releasing the Information**
Copy to Requestor