GREAT LAKES RECOVERY CENTERS, INC.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Section 1: Patient Information (please print)

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Last four digits of Social Security Number: ____ ____ ____ ____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number(s): Home:_____ Cell:_____ Email:_____

Section 2: Specific Health Information to be released or disclosed:

Dates of Service: From:_____(mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ Substance Abuse Assessment ☐ Mental Health/Psychosocial Assessment

☐ Sex Offender Assessment/Test Summary ☐ Psychological Evaluation ☐ Treatment Plans ☐ Progress in Treatment

☐ Urine/PBT Reports ☐ Attendance Record ☐ Discharge Summary ☐ Aftercare Plan

☐ Emergency Contact ☐ Medical Information (specify):_____

☐ Other (specify): _____

Section 3: Purpose of request/disclosure:

☐ Self/Inspection ☐ Continuation of Care ☐ Insurance ☑ Legal ☐ Other (specify): _____

Section 4: Format(s) preferred:

☐ To be printed and picked up by me

☐ Mailed to me at the address above

☐ Mail/Fax to another person identified in Section 5 below

☐ Oral Communication with person/business identified in Section 5 below

☐ Emailed to me (this is not secure; puts your records at risk)

☐ Storage device (flash/thumb drive) to be picked up by me (information is stored unencrypted; keep device secured)

Section 5: Third party to receive information ☐ N/A

Name:_____ Business: RECORDS DEPOSITION SERVICE, INC.

Street Address: PO BOX 5054 City: SOUTHFIELD State: MI Zip Code: 48086-5054

Phone Number: 248-357-3330 Fax Number: 248-357-3337 Email: INFO@RECDEP.COM

Section 6: Important information about this release:

- I agree to release information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). **Initials:** _____
- I specifically authorize the release of psychotherapy notes. **Initials:** _____
- I understand that Great Lakes Recovery Centers, Inc. has offices and programs in multiple locations. Client records and information may be shared across locations for billing and/or client services.
- I understand that the information being released may contain information about my behavioral health services and/or treatment for alcohol and substance use.
- I understand that records from other health care providers may be released with this request. Great Lakes Recovery Centers assumes no responsibility or liability for the accuracy or legitimacy of any records originating from another provider.
- This authorization is voluntary. Great Lakes Recovery Centers will not condition my continued treatment upon my signing this authorization.
- This authorization will expire one year from the date of my signature unless an earlier **date** is specified here: _____
- A photocopy of this release will be considered as valid as the original.
- I understand that I may revoke this authorization by written request at any time, but any information that has already been released will not be affected by my revocation.
- I am entitled to a copy of this release.
- I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by Federal or State law.
- Records relating to treatment for alcohol and substance use are protected from re-disclosure by Federal Regulation 42 CFR Part 2 and Public Act 258, which requires the receiving party to receive my written authorization to further disclose this information.
- Great Lakes Recovery Centers, Inc. has the right to charge for processing and copying information.

Section 7: Signature - By signing below I acknowledge that I read and understand this authorization.

_____ _____

Client or Client's Legal Representative Signature Date

_____ _____

Print Client or Client's Legal Representative's Name/Relationship Witness Signature

☐ **Identification confirmed if Legal Representative**