MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CENTER FOR FORENSIC PSYCHIATRY
P.O. BOX 2060, ANN ARBOR, MI 48106-2060
734-429-2531 FAX: 734-429-1817

Authorization for Disclosure of Records

CFP #: _____
(office use only)

Name: _____ Date of Birth: _____
(Please Print)

Address: _____
Street City State Zip

I hereby authorize the Center for Forensic Psychiatry (CFP) to disclose the protected health information indicated below to the following person or facility:

RECORDS DEPOSITION SERVICE, INC.
Name of Person or Facility

PO BOX 5054 SOUTHFIELD MI 48086-5054
Street City State Zip

Purpose of Release: PRE TRIAL DISCOVERY

Information to be Released: Approximate Date Range: From: _____ To: _____

____Admission Summary	____Discharge Summary	____Progress Notes
____Physical Exams	____Psychiatric Assessment	____Medical Consults
____Social Work Assessment	____Nursing Assessment	____Treatment Plan

____Court-Ordered Evaluation Report (specify)_____

____OTHER (please be specific)_____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

I understand that if I give permission, I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Officer, Center for Forensic Psychiatry, PO Box 2060, Ann Arbor, MI 48106-2060. I also understand that any uses or disclosures already made with my permission cannot be taken back. Unless otherwise revoked, this authorization will expire on the following date, event or condition. _____. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

_____ _____
Authorizing Signature Date

_____ _____
Guardian Signature (if applicable) Date

_____ _____
Witness Signature Date