AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

I, _____ (Name), hereby authorize DeLano Clinic (Name of person or organization)

7895 Currier Drive 2nd Floor (Address) Portage, MI 49002 (State & Zip Code) to release/exchange

the following information to/with RECORDS DEPOSITION SERVICE, INC. (Name of person or organization)

PO BOX 5054 SOUTHFIELD, MI 48086-5054 P: 248.357.3330 F: 248.357.3337

(Address) (State & Zip Code)

☐ Verbal Exchange of Information ☒ Send Information ☐ Obtain information from

SPECIFIC INFORMATION TO BE DISCLOSED: (Specific information must be checked. No box checked or request for any and all will not be accepted.)

Time frame of records needed: From: _____ To: _____

- ☐ 1. Assessments
- ☐ 2. Psychiatric Evaluation
- ☐ 3. Treatment Plan
- ☐ 4. Testing Results
- ☐ 5. Medication(s)
- ☐ 6. Medication Management Notes
- ☐ 7. Progress Notes
- ☐ 8. Appointment History/Summary of Treatment
- ☒ 9. Other Please see enclosed Subpoena or Letter
- ☐ 10. Other Request for information to be disclosed.

Any information not to be released: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Reason for Disclosure FOR DISCOVERY BEFORE TRIAL

This authorization will expire one year from the date of signature unless specified. I understand that my records are protected by State and Federal Confidentiality Rules and cannot be disclosed without my written authorization unless release is required by other regulations. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken. I understand that medical information may include records, if any, on alcohol and drug abuse, psychology, social work and information about HIV, AIDS, and ARC. I understand that treatment, payment, enrollment or eligibility for services will not be conditioned on signing this authorization. I understand there is the possibility the protected health information may be re-disclosed by the recipient of the information.

Signature _____ Date of Signature _____

Signature of Parent/Guardian/Legal Representative _____ Date of Signature _____

Description of Authority to Sign for the Client _____ **Signature of Witness** _____

NOTE: Faxed and Photocopied authorizations are not accepted.

NOTE TO RECEIVING AGENCY: This information has been disclosed to you from records protected by the Mental Health Code 330.1748 and the Federal Privacy Regulations. An individual receiving information made confidential by these regulations shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained. A general authorization for release of medical or other information is NOT sufficient for this purpose.

For Office Use Only:
Date Information Released/Exchanged: _____ Initials of person completing request _____
Specific Information Released/Exchanged: _____ *Initials of person verifying request* _____