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

CLIENT NAME **Jane R. Doe** DOB **01/11/1980** CLIENT # _____

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

FROM: **CEI Community Mental Health** (Organization / Person)	*TO:* **Jane R. Doe** (Organization / Person)
812 E. JOLLY RD (Address)	**555 Lake Drive** (Address)
LANSING, MI 48910	**Lansing, MI 48910**
Phone: **517- 346-8200**	Phone: **(555) 555-5555**

*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): *personal records*

SPECIFIC RECORDS / INFORMATION TO BE RELEASED *FOR THE TIME PERIOD:* ***FROM 1/1/2001 TO 3/22/2012***

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

Other(specify): _____

This authorization will expire on the following date **5/22/12**, or on the following event/condition ____(**60 days from signature date)**. 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.

Jane R. Doe	*self*	*3/22/12*
Client / Parent / Guardian Signature or Person Authorized to Sign in Lieu of Client	Relationship	Date

John Q. Doe (***witness can be friend, family, professional.***)
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