

Copper Country Mental Health - AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

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|--|--|--|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rice Memorial Center 901 W. Memorial Drive Houghton, MI 49931 Fax: (906) 487-7713 | Institute 900 W. Sharon Ave. Houghton, MI 49931 Fax: (906) 482-7657 | Baraga Center HC03 Box 957 L'Anse, MI 49946 Fax: (906) 524-5866 | C-L-K Office 1125 Calumet Ave. Calumet, MI 49913 Fax: (906) 337-2108 | Ontonagon Center 515 Quartz St. Ontonagon, MI 49953 Fax: (906) 884-4856 |

I hereby authorize Copper Country CMH to: release and/or request information from the record of:
 _____, date of birth _____
(recipient of services) (former names if applicable)

At: _____
Street Address City State Zip

TO / FROM: NAME: _____
 ADDRESS: _____

METHOD OF DISCLOSURE: Verbal Written Fax e-mail

PURPOSE: Coordination of Services Benefits Determination Other: _____

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| INFORMATION TO BE RELEASED* _____ to _____ <small>(Time Period)</small> <input type="checkbox"/> Clinical/Psychosocial Assessment(s) <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Treatment Summaries <input type="checkbox"/> Psychiatric Evaluation(s) <input type="checkbox"/> Health Care Assessment(s) <input type="checkbox"/> Prescribed Psychiatric Medication(s) <input type="checkbox"/> Notification of Hospitalization <input type="checkbox"/> Ongoing Assessment <input type="checkbox"/> Significant Changes in Services <input type="checkbox"/> Services/Programs Participating In <input type="checkbox"/> Other: (please specify): _____ _____ _____ | INFORMATION REQUESTED* _____ to _____ <small>(Time Period)</small> <input type="checkbox"/> Physician Progress Notes (dates: _____) <input type="checkbox"/> History/Physical <input type="checkbox"/> Discharge Summary (dates: _____) <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> X-ray Report(s) <input type="checkbox"/> EKG Report(s) <input type="checkbox"/> Clinical Assessments <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Academic/Behavioral Report(s) <input type="checkbox"/> Court Records/Legal Documents <input type="checkbox"/> Psychological/Psychiatric Evaluations <input type="checkbox"/> Prescribed Psychiatric Medication(s) <input type="checkbox"/> Other (please specify): _____ _____ _____ |
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*I expressly authorize information concerning the following to be released:
 Drug/Alcohol Abuse HIV/AIDS/ARC

NOTICE TO PARTY RECEIVING DRUG/ALCOHOL ABUSE INFORMATION:
 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I understand that, if CCMH is requesting the authorization for its own use, it will not condition the treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use of disclosure.

I understand that I may inspect or copy the individually identifiable health information or protected health information (PHI) to be used or disclosed. I further understand that I may refuse to sign the authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.

I understand that I can, at any time, change my decision and revoke my authorization (in writing) for releasing and/or requesting information as noted on this form. This authorization will automatically expire once the purpose for which it was signed is accomplished or by _____, or one year from the date of signature.

Recipient/Parent/Guardian: _____ Date _____
 Verbal Authorization Witness _____ Date _____