

COPPER COUNTRY MENTAL HEALTH SERVICES - Authorization for Release of Information 42 C.F.R. Part 2

<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) 482-9794	Institute 900 W. Sharon Ave. Houghton, MI 49931 Fax: (906) 482-7657	Baraga Center 15644 Skanee Rd. L'Anse, MI 49946 Fax: (906) 524-5866	C-L-K Office 56938 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 Mental Health to release information to and/or receive information from the record of:
 Consumer Name: _____ DOB: _____ Case # _____

Release to and/or receive from: _____ at _____
(Name of Individual, Facility or Organization information is authorized to be shared with)
 _____ Fax # _____
(Address, City, State, Zip Code)

The specific purpose of the disclosure authorized is:

<input type="checkbox"/> Coordination of Services	<input type="checkbox"/> Legal Investigation or Action	<input type="checkbox"/> Payment of Insurance claims
<input type="checkbox"/> Determination of Benefits	<input type="checkbox"/> Changing Physicians	
<input type="checkbox"/> At the request of the individual	<input type="checkbox"/> Other _____	

METHOD OF DISCLOSURE: Verbal Written Fax Secure e-mail

Information CCMHS is authorized to RELEASE:	Information CCMHS is authorized to RECEIVE:
Behavior Information	Behavior Information
Psychological/Psychiatric Evaluations	Psychological/Psychiatric Evaluations
Physician Orders	Physician Orders
Physician Progress Notes	Physician Progress Notes
Medication Reviews	History and Physical
Discharge Summary	Discharge Summary
Clinical Assessments	Assessments
Individual Plan of Service (IPOS)	Treatment Plans including medication lists
Periodic Reviews	Laboratory Reports
Health Care Assessments	X-ray Reports
Clinical Progress Notes	EKG Reports
Crisis Reports/Screenings DATE:	Academic information
Services/Programs Participation	Court records/legal documents
Other:	Other:

I **allow** the release of HIV/AIDS/ARC information. I **prohibit** the release of HIV/AIDS/ARC information.
 _____ Consumer Initials Completing this box is mandatory and does not indicate whether or not an individual has HIV/AIDS/ARC

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and Michigan Mental Health Code MCL330.1001 et seq. and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I also understand that I may revoke verbally or in writing this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows: Termination of services; purpose achieved; one year from signature date, or whichever occurs first.

I understand that I may refuse to sign the authorization. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that I may inspect or copy the individually identifiable health information or protected health information (PHI) to be used or disclosed. I have received a copy of this release.

Signature of Consumer: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____