Authorization for use and disclosure of protected health information

601 S Shore Drive Suite 224
Battle Creek, MI 49014
(269) 979-8119

Patient Name: ____ **Date of Birth:** __________

Address: ____**SSN:** _________________

Home Phone: ______________________________ **Work/Cell Phone:** ______________________

I, the undersigned patient or legal guardian, hereby authorize ______ verbal and/or ______ written information to be released **by**: ***Christian Counseling Center of Battle Creek (269) 979-8119***
601 S Shore Drive Suite 224, Battle Creek MI 49014

TO BE RELEASED TO:

Name of Hospital/Clinician/Third Party: ____

Phone: _________________**Address:** ____

I, the undersigned patient or legal guardian, hereby authorize ______ verbal and/or ______ written information to be released **to**: ***Christian Counseling Center of Battle Creek (269) 979-8119***
601 S Shore Drive Suite 224, Battle Creek MI 49015

TO BE RELEASED FROM:

Name of Hospital/Clinician/Third Party: ____

Phone: _________________**Address:** ____

Information to be Released:

__Psychiatric Evaluation __Psychological __Discharge & After Care Plan
__Medication Record __Psychological Testing __Progress Notes
__H&P/Lab-work __Treatment Planning
__Other (Specify)

Release of Information for the Following Purpose(s):

__Treatment/Consultation __Patient Request __Billing or Claims
__Attorney __Other (Specify) ____

- I understand that the information released may be ***(initial for release of the following information)***
  __Mental Health __Substance Abuse __HIV/AIDS Information
- I understand that this authorization is voluntary and that treatment by my provider cannot be conditioned on the singing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. This establishment and its providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by the state and federal Law.

This Release is effective from ____________________**to**_______________________

____ _____________

Patient or Legal Representative (Description/Proof of Authority to Act for Patient Must be Provided) ***Date***

____ _____________

Witness and Title ***Date***