Lansing Institute of Behavioral Medicine

Release of Information
Authorization for Disclosure of Mental Health Treatment Information

Patient Name: _____ DOB: _____Phone: _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION BETWEEN BOTH PARTIES INDICATED BELOW.
PLEASE INDICATE WHO IS TO BE SENDING THE INFORMATION AND WHO IS TO BE RECEIVING BY **CIRCLING BELOW:**

FROM	TO	FROM	TO
_____ (Provider Name)		_____ (Medical Office/Attorney/Workplace/Govt Agency/Individual/Other)	
Lansing Institute of Behavioral Medicine		Address _____	
3475 Belle Chase Way		City, State, Zip Code _____	
Lansing, MI 48911		Phone _____	
Phone: 517-882-3732		Fax _____	
Fax: 517-882-3633			

Description of Information to be Disclosed--Initial those that apply

____ Diagnosis Only ____ Medication Information Only ____ Appointment Attendance Document
____ Neuropsychological Evaluation ____ Diagnostic Psychological Interview ____ Treatment Summary
____ FMLA Paperwork ____ Long Term/Short Term Disability Paperwork
____Entire Medical Record ____ Medical Records ONLY for dates between _____and _____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. Please specify the purpose for the disclosure below:

____ Coordination of Care ___Transfer of Care ____At the Request of the Individual

Conditions

A request for disclosure of health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I understand that my records are protected under the applicable state law governing health care information and that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records 42 CRF Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

I further understand that Lansing Institute of Behavioral Medicine will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization will result in Lansing Institute of Behavioral Medicine not being permitted to release/disclose any of my information.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Medical Records Department at Lansing Institute of Behavioral Medicine at the address above. I further understand that revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed be the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration

Unless sooner revoked, this authorization expires **6 months** from the date of signature or as otherwise indicated here: _____.

_____ _____
Signature of Patient/Client Date Signature of Parent, Guardian, or Personal Representative Date

If you are signing as the personal representative of an individual, please describe your authority to act for this individual

_____ I have the option to request a copy of this authorization for my records
Signature of Staff Witness Date