PINE REST Christian Mental Health Services

AUTHORIZATION FOR RELEASE AND DISCLOSURE, AND/OR REQUEST FOR MEDICAL INFORMATION AND RECORDS

I,_____(patient), (_____date of birth) authorize Pine Rest Christian Mental Health Services to: (√ one or both below, or form is invalid)

_x__ release information from my medical records to the individual/organization listed below

____ request information from the individual/organization listed below

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Release of medical records by: □ MyChart □ Fax □ Mail □ *Encrypted Flash Drive (*additional $30 charge)

□ *Email (Please print legibly)_____

*(*Will only be sent via encrypted secure messaging. Requires account creation and login for retrieval.)*

For the following purpose, use, or need: _____

Treatment Dates: From _____ **To** _____

The following information from my psychiatric/medical records may be disclosed:

□ Treatment Summary □ Psychiatric Evaluation □ Psychological Testing □ Laboratory Studies □ Initial Assessment

□ Physical Exam □ Other _____

☒ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

□ Exclude the following information: _____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Health Information Management Director, and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations, Part II, with which this authorization complies. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Pine Rest will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or until the following date, event or condition:

_____

I have also had the opportunity to have this form explained to me and have my questions answered.

_____ _____ _____ _____

Patient/Parent/Guardian/ Personal Representative Signature | Date | Witness Signature | Date

Copy of this authorization provided: Yes_____ Declined _____

Return completed form to: 300 68th Street SE, PO Box 165, Grand Rapids, MI 49501-0165 – Phone (616)281-6349 – **Fax (616)493-6043**

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Guardianship Papers, Letter of Authority for Personal Representative, etc.