ROCHESTER CENTER
FOR BEHAVIORAL MEDICINE

441 South Livernois, Suite 100
Rochester Hills, MI 48307
Phone 248.608.8800 • Fax 248.608.2490 • www.rcbm.net

Consent for "Releasing" or "Obtaining" Confidential Medical Information

PLEASE READ THIS FORM THOROUGHLY PRIOR TO COMPLETING IT IN ITS' ENTIRETY.

Patients Name: _____ Birthdate: _____

Parent/Guardian's Name: _____ Patient's S.S. #_____

I hereby freely and voluntarily authorize Party Releasing Records to:

__ Verbally release/disclose my protected health information

__ Physically release my records

Physician/Organization/Person Releasing Records:		Physician/Organization/Person Receiving Records:	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
Phone:	_____	Phone:	_____
Fax #:	_____	Fax #:	_____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. It may also include information about behavioral or mental health services (Code 42 of Regulations, Part 2). I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice (Facility Name) Privacy Officer, except to the extent that action has already been taken in reliance on it. If not previously revoked by me in writing, this authorization is effective on this date and will expire one (1) year following discharge from treatment.

Information to be used or disclosed:

__Psychological Intake __Progress Report __Treatment Plan __Complete Records __Diagnosis __ Psychological Screening

__Other (explain) _____

Purpose of disclosure:

__Insurance Matters __Academic Matters __Legal Matters __Patient Request __Progress Updates __Referral for Services

__Coordination of Care (between RCBM & another provider) __Continuation of Care (continuation of psychiatric care with a new provider)

__Other (explain)_____

_____

Patient or Parent/ Guardian Signature Date

_____

Witnessed By Date