Community
MENTAL HEALTH
CLINTON • EATON • INGHAM
Together we can.

Authorization to Release Medical Records

Client Name: _____ DOB: _____ Client #: _____

I give permission to CMHA-CEI to release information pertaining to my/my child's/my ward's care to:

_____
Organization/Person

_____
Address, City, State, Zip

_____ _____ _____
Phone Number Fax Number Email Address

- I would like my records provided via: ☐ Encrypted Email ☐ Fax ☐ Mail ☐ Paper Form *(Must be picked up)*
- Reason for release: *(not required if you are an authorized individual)* _____
- I am requesting records from: _____ to: _____ Cannot be future dated
- I would like copies of the following documents:

☐ Case Management Notes	☐ Discharge Summaries	☐ Medication List	☐ Other:
☐ Assessments	☐ Crisis Plan/Notes	☐ Autism Evaluation	
☐ Treatment Plans	☐ Psychiatric Evaluations	☐ BCU Plan/Notes	
☐ Individual/Group Therapy Notes	☐ Diagnosis List	☐ CLS Notes	

- This authorization will last no longer than reasonably necessary to serve the purpose for which it is given.
- I have read, or have had read to me, this authorization form and understand:
  - I may withdraw this authorization at any time, unless action has already been taken based on this authorization.
  - This record may contain mental health, drug and/or alcohol use/abuse history, HIV, AIDS, or ARC information, as applicable to my/my child's/my ward's case.
  - That appropriate information from my clinical record may be released when needed for immediate client care (as defined in clinical policies 3.3.10 and 3.2.14).

_____ _____ _____
Client/Parent/Legal Guardian/Authorized Person Signature Relationship Date

_____ _____ _____
Witness to the Above Signature (if applicable) Relationship Date

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. **Further disclosure of this information is prohibited unless otherwise permitted by Federal and State laws.** (P.A. 258 of 1974, Section 748(3); P.A. 368 of 1978; 42 CFR Parts 160 and 164 (HIPAA); P.A. Act 488 of 1989). CMHA-CEI will not condition treatment, payment, or program eligibility on the signing of this authorization.

Please return this form to CMHA-CEI's Compliance Office at 812 E. Jolly Rd Ste.108 Lansing, MI 48910 or through email at compliance@ceicmh.org.