ST JOHN PROVIDENCE HEALTH SYSTEM | BRIGHTON CENTER FOR RECOVERY

Medical Record Fax: 810-220-5519

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

I, _____, **DOB:** _____ hereby authorize **BRIGHTON CENTER FOR RECOVERY**, its Director, designee or Health Information Department to:

*** [Initials Required:]**

1. **RELEASE Information To** [✓] **OBTAIN Information From** _____ **EXCHANGE Information With** _____

Name: _____ Organization: RECORDS DEPOSITION SERVICE, INC.

Street Address: P.O. BOX 5054 Relationship: AGENT FOR ATTORNEY

City: SOUTHFIELD State: MICHIGAN Zip Code: 48086-5054

Phone: 248-357-3330 Fax: 248-357-3337 Other: _____

I understand that information contained in my health record may include alcohol and drug abuse records protected under 42 Code of Federal Regulations, Part 2; psychological services records, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, that includes venereal disease, tuberculosis, HIV, AIDS, and ARC.

I understand that my protected health information (PHI) disclosed under this authorization may be re-disclosed by the individual or organization named above and its privacy may no longer be protected by law.

2. ***Specific type of information to be disclosed:*** [ ] **Inpatient** [ ] **Outpatient**

*** [INITIAL all types of information that apply to person/organization listed above.]**

____ Discharge Summary	____ Emergency Contact
____ Medication List	____ AMA Alert
____ History & Physical	____ Financial/Insurance Information
____ Admission Assessment	____ Acceptance of Special Deliveries
____ Treatment Plans and Reviews	
____ Psychosocial Evaluation	____ Admission/Discharge Letter (dates only)
____ Aftercare Plan	____ Completion of Program Letter
____ Lab Results and Urine Drug Screen	____ Completion of Benefit Forms
____ Psychiatric Evaluations & Medication Reviews	[✓] Other, Specify: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

3. ***Purpose and need for such disclosure:***

*** [INITIAL all the purposes and needs that apply to person/organization listed above.]**

____ Aftercare Planning	____ Continuity of Care	____ Emergency
[✓] Attorney	____ School	____ Payment of Bill
____ Court/Probation	____ Family Involvement / Therapy	____ Employer Request/Job Stability
____ Disability/FMLA Benefits	____ Other, Specify: _____	

4. This authorization may be revoked by me at any time, except in legal action cases, by my written notice to the above named individual or organization, except to the extent that the person or organization that is to make the disclosure has already taken action in reliance on my authorization.

5. This authorization is effective on the date below and will expire in 6 months if not previously revoked by me in writing.

6. Brighton Center for Recovery will not condition treatment, payment, enrollment or benefit eligibility on my signing this document.

7. I am voluntarily signing this authorization and understand what information is going to be released to the above named individual or organization. A copy of this authorization will be provided to me at my request.

_____ _____
Patient Signature **Date**

_____ _____
Legal Representative Signature **Date**

NOTICE TO PATIENTS AND VISITORS: For safety and security purposes, part of the Brighton Center for Recovery Buildings and Campus are under video surveillance.

BHO-09 Revised 042413

*** THIS AUTHORIZATION WILL BE INVALID IF THE AUTHORIZING INDIVIDUAL'S INITIALS ARE MISSING.**